THE UNITED STATES' WAR ON AIDS

HEARING

BEFORE THE

COMMITTEE ON INTERNATIONAL RELATIONS HOUSE OF REPRESENTATIVES

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THE UNITED STATES' WAR ON AIDS

THURSDAY, JUNE 7, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERNATIONAL RELATIONS,
Washington, DC.

The Committee met, pursuant to call, at 11:10 a.m. in Room 2127, Rayburn House Office Building, Hon. Henry J. Hyde (Chairman of the Committee) presiding.

Chairman HYDE. The Committee will come to order.

While the modern world has made great progress in medicine over recent decades, there is one horrific new killer that is stalking the globe, and particularly an entire, defenseless continent, Africa. Many of us believed that such a horrible epidemic, which cuts down people in the prime of their lives, was a thing of the past, but we now know that despite all of the wonderful medical progress of the 20th century, new killers can emerge.

The statistics speak for themselves. Twenty-two million people have died of AIDS worldwide, including more than 3 million last year. That is over 8,000 per day—or nearly six deaths every minute.

Tragically, the number is growing. By the year 2010, 80 million persons could be dead of AIDS. That is more deaths than all the military and civilian forces suffered during World War II. For someone who lived through that horrific period in war, this is a mind boggling statistic.

In Africa, where 70 percent of the AIDS cases are, the virus has been particularly devastating. Let me recite just a few of the alarming statistics. I am sure that our witnesses today will expand on the devastation and the challenges confronting the African continent and the rest of the developing world.

Life expectancy has been reduced by nearly half in many countries of Sub-Saharan Africa, including Botswana, Swaziland, and South Africa. The death of parents with HIV/AIDS will result in 40 million orphans this decade alone. In some southern Africa countries, 20 percent or more of the adult population is infected with HIV. The HIV infection rate has reached 35 percent in Botswana. In Swaziland, the statistic is estimated to be nearly the same.

National economies are being devastated, as trained personnel in key sectors die, these include teachers, health care personnel, and law enforcement personnel.

To date, eastern and southern Africa have been far more affected than west Africa, but infection rates in West Africa are climbing. The infection rate exceeds 10 percent in the Ivory Coast, and is increasing in Nigeria. An estimated 600,000 African children became

infected with the AIDS virus each year through mother-to-child transmission, either at birth or through breast feeding. These children have a short life expectancy, and the number of HIV-infected children in the region is currently estimated at 1 million.

Sub-Saharan Africa is the only region in the world where HIV/AIDS infection rates for women exceed the AIDS virus infection rate for men.

The United States Government has already made major contributions to the fight against the AIDS virus. Currently, the United States is contributing 300 million through the Agency for International Development to fight the scourge of HIV/AIDS in the developing world. The Center for Disease Control, Department of Labor, and Department of Defense have all also brought their expertise to bear on the pandemic. Government funding is helping to create a powerful coalition of Government, foundations, United Nations organizations, pharmaceutical companies, academic institutions, and scientific institutions to combat the HIV/AIDS pandemic.

The focus of our government's bilateral efforts are, of course, channeled through the Agency for International Development. To that end, this Committee will consider legislation to authorize AID funding for Fiscal Year 2002 at the highest level to date, $469 million in prevention and health infrastructure, and $50 million for a pilot treatment program for those who already suffer from HIV/AIDS.

Our first priority for Agency for International Development programs is prevention through education. Until medical research produces an effective vaccine, prevention through changes in behavior will remain the best and only truly effective means of overcoming the AIDS threat.

At the same time, recent initiatives by the pharmaceutical companies point the way toward less expensive medication aimed at treating those with AIDS. With sufficient resources, it is now possible to improve treatment options—provided that the health systems are able to deliver and monitor the medications. That is why we are eager to authorize funding for a pilot treatment program, including the purchase of medicines to help the poorest of the poor.

I am confident that in administering these programs, USAID will continue to rely on the fine work performed by community-based organizations, both religious and secular, to ensure the success of delivering not just medicine, but the health infrastructure to service endangered populations. Again, delivery systems and health infrastructures are absolutely essential if individuals are to benefit from the medications, as provided for by our bill.

This Committee will consider the authorization of microenterprise development and other similar programs that help HIV-infected individuals and their families cope with this challenge. I have also advocated the promotion of foster care-type programs in Africa as a way to help families and children suffer so much from the loss of parents who have succumbed to this deadly disease.

Lastly, the Committee will also consider an authorization of appropriations for the President to contribute to multilateral assistance efforts as mechanisms and appropriate levels are determined by the Administration in conjunction with governments of other de-

veloped countries, the United Nations, and private foundations engaged in the battle to stem the tide of the AIDS pandemic.

I wish to thank the many organizations that have assisted us in drafting this legislation to authorize bilateral HIV/AIDS programs. I am especially grateful to the President for his leadership and for elevating to the White House National Office on AIDS Policy International programs designed to combat the spread of the deadly virus.

I am appreciative of the contributions of Opportunities International, the Foundation for International Community Assistance, and the Log Cabin Republicans in promoting awareness on the growing threat of the HIV/AIDS pandemic.

In closing, I want to reiterate what I think is a consensus in Congress. Simply stated, the AIDS virus is one of the great moral challenges of our era for it is a scourge of unparalleled proportions in modern times. Every citizen has a stake in what tragically could be the black plague of the 21st century.

Accordingly, we should do all we can to meet this test by reaching out now to those most in need—it is the right thing to do for our children, our country, and our world. Let us not fail the challenge.

I am pleased to recognize the Ranking Democratic Member on the Committee, the gentleman from California, Mr. Lantos.

[The prepared statement of Mr. Hyde follows:]

PREPARED STATEMENT OF THE HONORABLE HENRY J. HYDE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS, AND CHAIRMAN, COMMITTEE ON INTERNATIONAL RELATIONS

While the modern world has made great progress in medicine over recent decades, there is one horrific new killer that is stalking the globe, and particularly an entire, defenseless continent, Africa. Many of us believed that such a horrible epidemic, which cuts down people in the prime of their lives, was a thing of the past, but we now know that despite all the wonderful medical progress of the 20th century, new killers can emerge.

The statistics speak for themselves. Twenty-two million people have died of AIDS worldwide, including more than 3 million last year. That is over 8,000 per day—or nearly 6 deaths every minute. Tragically, the number is growing. By the year 2010, 80 million persons could be dead of AIDS. That is more deaths than all military and civilian forces suffered during World War II. For someone who lived through that horrific period and war, this is a mind boggling statistic. In Africa, where seventy percent of the AIDS cases are, the virus has been particularly devastating. Let me recite just a few of the alarming statistics. I am sure that our witnesses today will expand on the devastation and the challenges confronting the African continent and the rest of the developing world.

- Life expectancy has been reduced by nearly half in many countries of sub-Saharan Africa, including Botswana, Swaziland, and South Africa. The deaths of parents with HIV/AIDS will result in 40 million orphans this decade alone. In some southern African countries, 20 percent or more of the adult population is infected with HIV. The HIV infection rate has reached 35 percent in Botswana. In Swaziland, the statistic is estimated to be nearly the same.
- National economies are being devastated, as trained personnel in key sectors die; these include teachers, health care personnel, and law enforcement personnel.
- To date, eastern and southern Africa have been far more affected than West Africa, but infection rates in West Africa are also climbing. The infection rate exceeds 10% in the Ivory Coast, and is increasing in Nigeria.
- An estimated 600,000 African children become infected with the AIDS virus each year through mother-to-child transmission, either at birth or through

breast-feeding. These children have a short life expectancy, and the number of HIV-infected children in the region is currently estimated at 1 million.

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Mr. LANTOS. Thank you very much, Mr. Chairman. Let me first commend you for your eloquent and powerful statement, for holding this hearing and for the leadership you are providing.

Let me also state at the outset how deeply disappointed I am that the Administration, as I understand it, pulled out its witness in the last minute for reasons that I do not know and perhaps we will learn later, but I think it would have been singularly appropriate for the Administration to have its coordinator here.

Mr. Chairman, this week marks the 20th anniversary when the HIV/AIDS virus first was identified. In 1991, the World Health Organization projected around 18 million cases worldwide by the year 2000. In fact, there are over 36 million cases, double the earlier prediction.

The tragedy of HIV/AIDS is reflected most harshly in the lives of the young and the poor around the globe. Today, a 15-year-old boy in Botswana has a 90 percent chance of dying from AIDS or an AIDS-related disease. This last week, 12-year-old Nkosi Johnson, South Africa's youngest AIDS activist, died having lived his whole short life with this disease.

I am very pleased that today the House International Relations Committee is holding a hearing on the global HIV/AIDS crisis. Without a doubt, this pandemic may threaten the very survival of entire nations in the third world.

Often we begin these meetings by reciting statistics, but the numbers in this instance are truly staggering and awe inspiring:

There are 36 million people living with HIV/AIDS globally.

Last year, there were over 5 million new HIV infections, 2.2 million women and 600,000 children under the age of 15.

Last year, 3 million people died, including half a million people.

Since the beginning of the epidemic, 22 million people lost their lives.

As we all know, the continent of Africa has borne the brunt of this disease, so far accounting for some 75 percent of those living with and dying of AIDS. Southeast Asia is just beginning to manifest as the next epicenter of this tragic disease. No continent or country is spared.

While HIV/AIDS knows no national, religious, ethnic or economic boundaries, the fact remains that globally this disease is linked directly to poverty. Those most vulnerable are likely to be poor, female and of color.

As Secretary Powell said recently in Nairobi, Kenya, this is more than a health issue, this is a social issue, this is a political issue, this is an economic issue, this is an issue of poverty.

As this epidemic has swept from continent to continent, an international consensus has emerged. No one country can deal with the HIV/AIDS crisis by itself. A bold new multilateral initiative with a long-term view toward preventing, treating, monitoring and eventually curing this disease is required. Nothing less will do.

Mr. Chairman, I personally want to commend you on the HIV/AIDS legislation you have introduced this week. Your willingness to bring forth this legislation clearly states the sincerity and the intent of yourself and of this Congress to fight this epidemic. Surely the policy framework that you propose steers our government efforts in the right direction and I look forward to working with you over the coming weeks to strengthening your bill and it is my hope that we can have a strong bipartisan initiative that will help guide the rest of the world, particularly the wealthiest nations, toward shouldering our responsibilities collectively for the sake of human kind.

At the African summit on HIV/AIDS held in Abuja, Nigeria this past April, my good dear friend Kofi Annan called on the world to

rally together and create a global fund to combat this disease and related opportunistic infectious diseases.

Mr. Annan estimated an annual cost of $7 to $10 billion. According to UNAIDS, currently one-tenth of that is being spent to combat this disease.

Kofi Annan appealed to governments, foundations and the private sector to join together and make the global fund a reality and, as you will recall, Mr. Chairman, when we had breakfast with Mr. Annan a couple of weeks ago, I offered to do my best to assist in raising in the private sector the funds that might make his dream a reality.

Mr. Chairman, this is where the United States' role as the world leader in the battle against HIV/AIDS must begin. I want to commend the Administration for the attention it is beginning to give to the global HIV/AIDS crisis. The Administration has decided to retain the critical Office on AIDS policy in the White House. The Administration announced a $200 million initial contribution to a global trust fund and it has requested $369 million for U.S. aid for 2002 and I want to commend you, Mr. Chairman, for going above the Administration figures.

Secretary of State Powell's recent comments in Africa offering hope directly to the poorer victims of this disease have been very helpful in signaling our willingness to step up and lead the fight against this dreaded disease.

I regret to conclude, however, that our financial commitment to fight HIV/AIDS globally does not reflect the leadership the United States should be exercising among the nations of the world. With the number one priority of the Administration in the field of tax cuts skewed to the wealthy, at a time when every hour of the day some poor woman somewhere is stricken, and some poor child is orphaned, we ought to be able to do better than what the Administration is proposing.

While our total annual financial commitment to fighting AIDS globally may sound good in terms of raw numbers to some, it is a paltry sum in terms of our wealth and what we can truly afford to fight this disease.

I believe the United States should commit itself more aggressively to at least doubling our bilateral assistance and making a major contribution to the global HIV/AIDS trust fund.

Mr. Chairman, I hope during this Congress we will move boldly in this direction and I pledge my efforts to achieve our goals.

Thank you, Mr. Chairman.

Chairman HYDE. The gentleman from New York, Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

Mr. Chairman, I want to commend you for holding this important timely hearing. It is heartening that we have made some progress, though we have much more to accomplish, in fighting the AIDS virus in the United States and throughout the world. And now thanks to the efforts of the Agency for International Development, the Center for Disease Control, the Department of Labor, the Defense Department and the private sector, hopefully, we will begin to make similar progress in the fight against AIDS in other lands.

To this end, I strongly support our Committee's intention to authorize AID funding for fiscal year 2002 to the highest level to date, $469 million in prevention and health infrastructure, and an additional $50 million for a pilot treatment program for those who already have the HIV virus.

I understand that even though you have increased some of the funding, that is about as much as could be absorbed at the present time and we are hoping that we can work together to find other means.

A Central Intelligence Agency National Intelligence Estimate report on the infectious disease threat made public in the unclassified version in the year 2000 forecast grave problems over the next 20 years and they state in that report, and I quote, "At least some of the hardest hit countries, initially in Sub-Saharan and later in other regions, will face a demographic catastrophe as HIV/AIDS and associated diseases reduce human life expectancy dramatically and kill up to a quarter of their populations over the period of this estimate. This will further impoverish the poor, and often the middle class, and produce a huge and impoverished orphan cohort unable to cope and vulnerable to exploitation and radicalization." That is from a CIA report entitled "The Global Infectious Disease Threat and Implications for the United States."

Dealing with this devastating illness, the AIDS virus has been one of the great moral tests of our era. Having made some progress at home, the question is whether we can now act to help those in more distant lands.

The Chairman's legislation, H.R. 2069, meets that challenge head on and I am proud to support this significant legislative initiative that builds on the Committee's previous work on infectious diseases.

Mr. Chairman, I look forward to listening to our distinguished panelists who are here this morning as we review our Committee's consideration of this devastating problem.

Thank you, Mr. Chairman.

Mr. SMITH. Thank you.

The gentleman from Ohio, Mr. Brown.

Mr. BROWN. Thank you very much, Mr. Chairman. The U.S., as others have said, must increase its involvement in the fight against AIDS. Over the next decade in Sub-Saharan Africa alone, AIDS will kill more people than the total number of casualties from all of the World Wars of the 20th century.

We also must more actively engage in global tuberculosis control. TB is AIDS's deadly partner in the worst pandemic in human history. TB is the leading killer of people with AIDS. To fully and effectively address the AIDS pandemic, we must also address the skyrocketing HIV–TB co-epidemic. In many parts of Africa, these diseases are inseparable. It is often assumed that when someone has TB they also have AIDS.

It has been estimated that half of the people with AIDS worldwide will develop TB. In parts of Sub-Saharan Africa, TB rates have quadrupled since 1990 due to AIDS. In some countries in Africa, 70 percent of TB patients are HIV positive.

HIV severely weakens the immune system, which in turn renders a person more susceptible to becoming sick with tuberculosis.

An HIV positive person is 30 times more likely to develop active TB and become infectious to others. There is also growing evidence that active TB actually accelerates the course of AIDS, making an individual sicker sooner.

TB treatment is one of the best ways to increase the life span and improve the quality of life of someone with AIDS. There are few more important things we can do right now to combat AIDS than to combat TB. A person with AIDS who has become sick with TB has a survival time on the average of five to 6 weeks. Directly Observed Treatment, short course, so called DOTS, at a cost of less than $50, that treatment can extend a person's survival time to 2 to 5 years and protect against the spread of TB in areas of high AIDS incidents. However, DOTS is reaching only one in four of those sick with TB worldwide.

In our fight against AIDS, it is imperative that we also address the deadly co-infection of AIDS and TB. We should provide a major increase in bilateral AIDS funding. $200 million for the treatment of TB is a crucial component in the fight against AIDS.

We should provide funding for the new global TB drug facility. $20 million—only $20 million annually—for this TB drug facility could provide TB drugs to 1 million people.

I also urge the Committee to ensure a major U.S. commitment to the new global AIDS health fund, as my friend Mr. Lantos mentioned, which has been proposed by the U.N. Secretary General Kofi Annan, on the order of a billion dollars or more of new money for proven, on-the-ground prevention and treatment.

I would also echo Mr. Lantos' comments that the tax cut that the President is signing today, hundreds and hundreds of billions of dollars, is money we could have used for this treatment. We talk over and over about how generous we are as a Congress—we are increasing these dollars to unprecedented numbers, more than we ever have in the past. Well, in the past we never did nearly enough and we are still not doing nearly enough.

Tackling TB means tackling HIV/AIDS as the most potent force driving the TB epidemic and tackling HIV/AIDS means tackling TB as a leading killer of people with HIV/AIDS.

I thank the Chairman.

Chairman HYDE. The gentleman from Iowa, Mr. Leach.

And I wonder if Mr. Leach would yield to me briefly.

Mr. LEACH. Of course. I would be delighted to yield.

Chairman HYDE. Thank you, Mr. Leach.

I would like to respond to the comments that this is a paltry sum and that we are not doing enough. I fully expected that. I asked the staff to come up with a figure that is the maximum possible to be absorbed by the recipients and to be effectively administered. There are limits to how much you can spend that can be usefully used, especially in programs like this.

We are providing $1 billion for 2 years—$1 billion for 2 years—bilateral aid. That is from us to agencies around the world. One billion.

Next, there is a comprehensive $1.2 billion that is spent on research in this country.

We are providing for up to 25 percent of whatever funds are contributed to an international fund.

And so those are substantial—not immodest—sums of money and I just wish that we could get past the politics and talk about trying to get some cures going.

Mr. BROWN. Would the Chairman yield?

Chairman HYDE. Sure.

Mr. LEACH. I would be delighted to yield.

Mr. BROWN. Oh, I am sorry. It is still Mr. Leach.

Thank you, Mr. Leach.

Yes, we should get beyond the politics and that is what we always say around here after we accomplish a public policy that is very different from what I think most people in this country want. When we do a tax cut like that, it does put a straight jacket on efforts of this Congress and with USAID, we have cut USAID over the years to the point that the infrastructure is not in place to deliver a lot of these services and, second, there are places this money could go. More money could go to WHO, more could go to CDC, both also cut under the Bush budget.

Chairman HYDE. The gentleman will have an opportunity to offer amendments that line up the money the way he prefers. He can do it better, he is sure welcome.

Mr. Leach?

Mr. LEACH. Thank you, Mr. Chairman. First, I want to thank you for your thoughtful introductory comments and identify with the wisdom of your decision to move forward in this arena so forthcomingly.

I would just like to comment a little bit on process and about the past and the future.

In the last Congress, we passed a bill called H.R. 3519, which was entitled "The Global AIDS and Tuberculosis Relief Act" which was a 2-year, $300 million authorization to establish an AIDS trust fund, a multilateral trust fund, to be administered by the World Bank. Unfortunately, only a small amount of appropriations came to be attended to that, in no small measure because the U.S. Agency for International Development objected, the White House objected, and the Treasury did not support it. And there was a phenomenal opportunity at the end of the last Congress for this to proceed.

Now it is clear in the international community there is an increasing consensus about a multilateral approach and recognition that the World Bank is the appropriate place to leverage other countries' monies, as well as use resources of the United States, and that it has an infrastructure perhaps second to none, although there is some competition. AID has a decent infrastructure, the U.N. in another area has a decent infrastructure.

But all I am stressing is in terms of process that I think there is a significant role for AID, there is a significant role for the World Bank, there is a significant role for other U.N. agencies, but I would hope that the AID would reassess some of its singular concerns that were evidenced at the end of the last Administration. I am very concerned about this because self-centeredness at a domestic institution can have massive ramifications for the worldwide approach. I am for everyone participating and I am particularly anxious to see that the international multilateral efforts also get off the ground.

I want to end by being complementary of your institution because you have begun to take steps with this approach of our distinguished Chairman and they will be even more significant and I am very appreciative of Chairman Hyde and his leadership in this area.

Thank you.

Chairman HYDE. I thank the gentleman.

We will take two more opening statements and then the rest of you, if you have any, may submit them for the record and they will be made a part of the record.

Mr. Sherman next and then Mr. Smith and then we will get to the witness.

So Mr. Sherman?

Mr. SHERMAN. Thank you, Mr. Chairman. I have incredible regard for the good gentleman from Iowa, but I could not disagree with him more as to whether it is better to go through USAID and institutions we control versus using the same amount of money through the international institutions.

We have seen the U.N. Human Rights Commission taken over and turned into a mockery. It has a good name—Human Rights is a good name. United Nations sounds like a good name. And yet just giving money to an organization that has a good name does not mean that good things or good control will result.

I know you mentioned the World Bank. I keep it hidden in my district because I want to keep voting for foreign aid, but the World Bank has taken our tax money and given it to the government of Iran just last year, over American objections. I asked the president of the World Bank for some assurance that his organization, in the guise of helping the poorest of the poor or helping those with AIDS, not give our tax money to the government in Khartoum and he refused to give me—could not give me—that assurance.

So multilateral organizations sound very good, but what can actually happen, and sometimes we even see it and it is blatant. For example, when we are kicked off the U.N. Human Rights Commission and Sudan and Syria are put in our place. Sometimes it is less, sometimes it is just unavoidable corruption, but we see our tax dollars going or potentially going to the most putrid regimes and it is not just that the money would be wasted. I am sure sometimes our bureaucracy will waste some money. It is that that money is then spent to oppress people, then spent to kill people. But it is not just that.

It is that if 20 or 50 million of our dollars are used for the worst possible purposes, then how do we defend foreign aid as a concept from those who would cut it back even further? And, as a result, we may lose billions of dollars over a decade because we allowed our foreign aid to go to sources that the American people simply cannot tolerate.

So I agree with the gentleman from Iowa, that in designing our tax and budget policy we should provide for the greatest possible within reason expenditures on dealing with problems like AIDS particularly in Africa, but we also have to be very careful as to how that money is spent. And once you give it to an organization where we lack control, then it is going to be given to Iran, as the World Bank did, and it may be given to the government of Sudan, not just

to the people, but to the government of Sudan. And then those of us who advocate even more expenditures on foreign aid can do nothing more than hope that our constituents become unaware of how their money is being spent.

Mr. LEACH. Will the gentleman yield?

Mr. SHERMAN. How much time do I have? I will yield for 30 seconds.

Chairman HYDE. You have a long 1 minute and 52 seconds.

Mr. SHERMAN. I will yield 30 seconds to the gentleman from Iowa.

Mr. LEACH. Well, you are gracious to give me——

Mr. SHERMAN. I will yield a minute to the gentleman from Iowa.

Mr. LEACH. Thank you for your graciousness.

I would only say to the gentleman, for whom I have great respect, that critiques of certain lending policies of all of these institutions are virtually always valid at any point in time. But I think one has to look at the AIDS issue itself and how they are performing on this subject. And I will tell you from firsthand knowledge that the U.N. is doing a pretty good job with limited resources with AIDS. The World Bank is doing a very good job.

I am not suggesting that we only go multilateral. I am suggesting we go all directions, multilateral and bilateral.

I am also suggesting, sir, that if you do not go multilateral, you cannot utilize the resources of many other countries in this effort. And if we want to put our heads in the sand, we have that option.

Finally, at the risk of true presumption, I mean, it should be understood the World Bank is headed by an American, it has always been American-led. It has to be attentive to the concerns of other countries the way decision making is made, but in this AIDS arena, I think we can take it out of the whole context of many of the concerns that people have, whether they be Middle Eastern issues, whether they be terrorist issues, whether they be anti-democratic issues in some countries. This is simply about human life and I think we have to take our blinders off.

Mr. SHERMAN. Reclaiming whatever remains of my time, I would simply say——

Chairman HYDE. Would the gentleman like an additional minute?

Mr. SHERMAN. I would love an additional minute.

Chairman HYDE. Without objection.

Mr. SHERMAN. Thank you, Mr. Chairman.

I do not think that those of us who are wary of what could happen have our heads in the sand. You cannot rise above politics, I would love to, but my tax dollars are going to the government of Iran right now and is it not wonderful that we have an American who heads the World Bank, but I have talked to him and he cannot assure you or me that this money will not go in the name of AIDS to guns to the government of Sudan, packaged as money to fight AIDS.

So I think our domestic organizations do an outstanding job. I have seen it. You have seen it. Neither one of us has any criticism of USAID. And I would point out that, yes, our unilateral efforts also do just as much to leverage because when legislatures in Belgium or in Germany or in Tokyo look at the total amount we

spend, they will decide to spend as well. They may decide to do it through their own organizations, they may do it in cooperation with us, but I do not think the nations of the world are going to say, oh, well, we do not have to do anything because the Americans are working through USAID rather than the World Bank. They will also act, either unilaterally or multilaterally. And if they do not, shame on them.

Chairman HYDE. The gentleman's time has expired.

The final opening statement will be delivered by the gentleman from New Jersey, Mr. Smith.

Mr. SMITH. Thank you very much, Mr. Chairman. I would ask that my full statement be made a part of the record and I will be very brief.

Chairman HYDE. Without objection.

Mr. SMITH. Thank you.

First of all, I want to thank Chairman Hyde for his foresight and for his vision in offering this new and, I think, very urgently needed legislation to help combat this epidemic of worldwide HIV/AIDS. It is compassionate legislation and, as I said, it is vitally needed.

I also want to welcome Mr. Natsios, who has a distinguished career at USAID and the State Department. I remember when he worked as the Director of Office of Foreign Disaster Relief. If ever there was a disaster that cries out, even though it is not an earthquake or tsunami, it is this AIDS epidemic and I cannot think of anyone better to be at the helm in trying to mitigate and hopefully end this cruelty than Mr. Natsios, so the money and the policy are in good hands with him at the lead.

I also just want to make one brief point. Government-wide, we spent in fiscal year 2000 $10.9 billion on AIDS, which is a tremendous and very worthwhile commitment. It is worth nothing, though, how that money is divided up: 58 percent is for treatment programs, research gets about 19 percent, income support programs 13, and prevention programs about 10 percent.

It seems to me that on the international side, the treatment side has been neglected for far too long. The slims—whatever one wants to call it in Sub-Saharan Africa, the devastation that is visited upon the individual and their family who waste away with little or no treatment, that has to come to an end and it seems to me that this bill is a significant down payment in saying treatment matters.

Also, the mother-to-baby transmission, I remember when Glaxo Wellcome some years back offered that they would at cost provide the drugs that lessened the possibility of transference of HIV to the child during childbirth.

When Brady Anderson from AID and others would come, I repeatedly would ask the Administration to be doing more in that regard. I do believe they did some, but much more needs to be done to make sure that those powerful drugs that can mitigate and even stop the transference of AIDS will be given and administered during the birthing of a child to save at least another generation from contracting this horrific disease.

So, Mr. Hyde, I want to salute you and thank you for taking the lead. I personally will be out chairing my own hearing. I will come back. It is on the GI bill which is totally unrelated, but I want you

to know I look forward to working with you, Mr. Hyde, and, again, thank you for the leadership.

Chairman HYDE. Thank you.

I would like to welcome Andrew Natsios, Administrator, U.S. Agency for International Development.

Congratulations, Mr. Administrator, on your recent confirmation and we do look forward to working closely with you and the President on the HIV/AIDS pandemic and other development challenges throughout the world.

Mr. Natsios' distinguished career includes service as the First Director of the Office of Foreign Disaster Assistance from 1989 to 1991 and as Assistant Administrator for the Bureau of Humanitarian Response at AID. Before assuming his current position, he was Chairman and Chief Executive Officer of the Massachusetts Turnpike Authority and Secretary for Administration and Finance for the Commonwealth of Massachusetts. He has also served as Vice President of World Vision, a distinguished academic, author, public servant and retired Colonel.

We are honored to have you appear before us today and please proceed with a 5-minute summary, if possible. Your full statement will be made a part of the record.

Mr. Natsios.

STATEMENT OF THE HONORABLE ANDREW NATSIOS, ADMINISTRATOR, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

Mr. NATSIOS. Thank you, Mr. Chairman. First, I would like to thank you for having me before the Committee and allowing me to testify. I have been on the job just about a month now.

I would also draw your attention to the map we have put up here which is a color-coded map of the infection rates. The maroon countries in the southern part of Africa are the highest rates; next are the red; then the yellow is the next highest. The lowest rates are the blue and the dark green. This will give you some sense of the pathology of the disease from a geographic standpoint.

We have copies of the maps to you directly, you can see the countries more closely there.

We submitted one piece of testimony to you which is an analytical piece, which I will not read, and then we submitted a second one today which is a more scholarly piece that precisely goes through our program over the last 15 years in AIDS because we are not new to this. We started our programming in Africa in 1986 during my service in the first Bush Administration in AID. This was a major issue even then.

What I would like to do is verbally, extemporaneously sort of summarize what is in the testimony and then perhaps answer some questions.

The President decided to focus on this issue just after he was sworn in as President and he did three things. The first is that he appointed Secretary Powell and Secretary Thompson to co-Chair a task force, a presidential task force, on the pandemic in the United States and worldwide.

Second, we made the first and the only donor contribution to this international trust fund. There are conversations going on literally

among donor governments right now, I think there were two meetings this week on it, as to the governance system and the strategy. There is still discussion as to how we should spend this money and where it should be spent, how it should be focused, who should be on the board of governors of this trust fund.

The third thing that happened, I think the most significant in some ways, is that the President dispatched Secretary Powell and I and other senior people from the State Department to go to Africa—we just came back last Wednesday—to focus international attention on the pandemic. We visited AIDS clinics, we visited AIDS research centers, we visited AIDS orphans, community programs that take care of these orphans. We met with heads of state and health ministers to focus international attention on what is happening.

There is a lot of talk about how much is spent, but just as a matter of course, the U.S. Government through AID and CDC spends more money on the pandemic than all governments of the world, sovereign governments, donor governments, multilateral agencies and U.N. agencies combined.

The HIV pandemic is one of the most serious crises, not the only crisis, but one of the most serious crises facing the developing work, particularly Africa where 70 percent of the HIV positive people live. In some areas of South Africa, and the secretary and I were in South Africa very recently, funerals are being held continuously from dawn until night because there simply are not enough funeral homes to deal with the number of people who have the disease who are now dying.

We have reports from our mission in Zimbabwe, in Harare, where metal street signs are disappearing every night. No one could understand at first what was happening and the newspapers in Harare are reporting that they are being stolen to be used for handles for coffins.

There is one report from one area, I heard from an NGO in South Africa, that they are burying people vertically instead of horizontally because there is no space left in many of the cemeteries in South Africa.

We know when the infection rate exceeds 4 to 5 percent, that is the threshold above which the pandemic grows at geometric proportions and the infection begins to spread almost out of control out of that level.

Three countries in Africa will have negative population growth rates by 2003 and five countries will have zero population growth by 2003. Zimbabwe, which has a population of 12 million people, will have 9 million people by 2010 because of the progress of the disease. It is so acute in Zimbabwe.

There are now 12 million AIDS orphans in Africa alone. In Uganda, another country that the secretary and I visited, there is a famous grandmother who lost her husband and 11 of her 12 children to AIDS. She has one daughter still alive. And they are caring for 31 grandchildren and four great-grandchildren.

Several NGOs have been formed in several countries because there are so many elderly people taking care of grandchildren. All they do is plow the fields because the elderly are simply too old to physically plow the fields. And if you do not plow the fields, agri-

cultural production, which is already in trouble in Africa, deteriorates further.

There are three reasons why in Africa we are now seeing famine-like conditions in areas where there should be no famine. Africa is plagued by civil wars, that is one cause of the collapse in agricultural production and starvation. The second is there are droughts sometimes, but the third is the AIDS pandemic. People are not able to plant the crops because there is no one functional. Everybody is either very young or very elderly and there is no one left in between to plant crops and so you are seeing famine-like conditions arising in rural areas which should be prosperous.

In Zimbabwe, more teachers are dying each year than are being trained in the teachers' colleges.

Now, this disease, unlike most of the infectious diseases that agencies like AID and the NGO community have to deal with, is a new disease. It developed in the 1920's and there is a great deal we still do not know about the pathology of the disease. That is why the National Institute for Health is spending $2.2 billion a year on research. Research, by the way, which is critical toward finding a cure, a vaccine, which can help us understand how to prevent the spread of the disease over a period of years. So we are spending nearly $3 billion between research and prevention programs alone.

This year, AID is spending $340 million in CDC, another $100 million internationally in the developing world on this disease. The fastest rates of growth are now in the subcontinent, South Asia, and in the former Soviet states. There the rates are more rapidly expanding. Asia is basically where Africa was 10 years ago and we are seeing rising rates in a number of Asian countries.

Now, we have learned a lot since 1986 about what works and what does not work. What we have done is field tested a whole series of different programs and as soon as we know something works to drive the rates down of infection, we begin scaling that up to a national scale. That is the strategy AID has been using and our principal objective is to save the largest number of lives with our given resources.

There are six strategies we are pursuing. The first one is prevention. I say that and I have to say it again, prevention is the center of the AID approach. There is no cure for AIDS, there is no vaccine for AIDS. And, therefore, the way to stop the pandemic is to stop it from spreading.

We know that, for example, if we treat sexually transmitted diseases like syphilis and gonorrhoea that the infection rate for AIDS drops by 50 percent. The spread of the disease drops by 50 percent when we treat just sexually transmitted diseases. We know if we give one pill to a mother and to her newborn child at birth that the infection rate will drop by 50 percent, as will the chances for that child being infected. So there are a series of things we know from a medical standpoint that work.

We also know that counselling programs, especially direct counselling for teenage girls in particular, have been very successful in postponing sexual debuts by several years and has dramatically dropped the rates of infection, particularly in countries like Uganda

where they have done a national program with our support to do that.

The essence of the prevention program is abstinence, faithfulness, and the use of condoms. Last year, AID alone distributed 300 million condoms in Africa, so we have a massive program in condom distribution now all over Africa. We have a huge infrastructure we have built up over the last 15 years to do that.

We are beginning a new faith-based initiative in Africa. The two principal institutions that influence people's behavior at the local level are the mosque and the church. I met with Muslim and Catholic leaders in Mali and in Uganda, I met with Muslim doctors and Muslim leaders and Pentecostal, Anglican and Catholic bishops to talk to them about what they are doing at the parish level to prevent the spread of the disease because they are the most influential institution in changing people's behavior. They have been doing things for years. We need to support them in doing that and there is a program that we are about to launch, we are doing the RFP now, to help us help them to do this work at the grassroots level where it is most effective.

We know that voluntary testing has a profound effect on behavior. Now, when I first heard this from our staff, I thought that if a person found out that they were HIV positive they would behave better, and they do. But we also find out when a person knows that they are HIV negative and they do not have the disease, that they also change their behavior. In other words, what encourages bad behavior is not knowing and once they do know, it encourages much more responsible behavior. So testing programs are being revamped in many countries now because we know that that information has a profound effect on people's behavior.

In terms of care for people who have the disease, because 29 million people have the disease in Africa right now, the first strategy is the treatment of opportunistic diseases. Congressman Brown mentioned this earlier. Tuberculosis is the principal disease that we focus on. Secondly is malaria. If you get malaria and you are HIV positive, your death rate is very high, very likely and very quick. And pneumonia is another problem. If you get pneumonia and you have HIV/AIDS, you shorten your life very quickly. And you do as well with dysentery, which is a problem among children in particular. So we do not treat this alone. It has to be treated in the context of other infectious diseases.

We also know that because of the serious problem we have with AIDS orphans. For example, we were in Kenya recently, the secretary and I, and there were a million AIDS orphans. It is overwhelming even the traditional capacity of the tribes to adopt children. Africa is not a place where orphanages make a lot of sense. They make more sense in the west, they do not in Africa, because there is a tribal tradition that when a child is orphaned someone in the tribe adopts the child very quickly. It is an old tribal tradition, actually, we have something to learn from the Africans, in my view. And they do that very easily and very quickly. The problem is it is overwhelming in the system.

So we just announced in Uganda a $40 million, 5-year program to provide food to the grandmothers of Uganda who are caring for their great-grandchildren and grandchildren or for parents who

adopt a lot of orphan children so they can feed them and pay their school fees as well to keep them in school.

We need to know more about surveillance. If we do not know how the disease spreads, we cannot combat it, so one of the things we are doing with Ministries of Health and through the NGO community is to set up surveillance systems to study the statistical data, the movement of the disease and how we can deal with it.

We need to get other donor governments involved in this. While we are spending $440 million this year, the next biggest donor is the European Union and they are at $90 million; the World Bank is at $70 million. This global trust fund, one of the purposes of it was to act as an incentive for other donor governments to give money and, secondly, to develop a unified strategy.

We believe all the technical people in the donor governments all agree, prevention has to be the focus. The problem is when you step above that at the political level, there starts getting a lot of debate about other approaches which may not be, from a clinical standpoint, the best way to approach this.

And, finally, my last comment, Mr. Chairman, is we need to take a multi-sectoral approach. The Secretary of State said that repeatedly; he is absolutely right. There are public safety problems when

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rian President Olusegun Obasanjo. Noting that "We have the power to help," President Bush said, "The United States is committed to working with other nations to reduce suffering and to spare lives." Currently the U.S. spends more money through USAID and the CDC on HIV/AIDS work internationally than all other donors combined. Since 1986, USAID has provided $1.6 billion in HIV/AIDS assistance. President Bush has pledged $200 million to the Global HIV/AIDS and Health Fund. This is in additionthat to the $350 million requested for USAID in 2002, the nearly $300 million for international HIV/AIDS work planned by other U.S. agencies, and the billions of dollars which the U.S. spends on HIV/AIDS domestic research and treatment.

I have just returned from a trip to four African countries with Secretary Powell, to talk to leaders about the problem of HIV/AIDS. We saw first-hand:

- The devastation caused by the pandemic: Most of those with HIV live in Africa although infection rates are rising rapidly in the rest of the world. In Africa because of HIV/AIDS, many families are no longer able to farm and many will go hungry. We are seeing famine caused for the first time not by war, drought or pestilence but by the HIV/AIDS pandemic.
- Too high a human toll: Already more than 17 million Africans have died, 12 million have been orphaned and another 25 million are living with HIV/AIDS. Unfortunately, many of these individuals will suffer alone; receive no modest care; die too young and in pain; and leave behind destitute families and children.
- The strategic importance of prevention programs to reduce the rate of new infection. Tragically, in developing countries, about half of all new HIV infections are to 15–24 year olds. The behavior of today's youth will shape the course of the AIDS pandemic in the future.
- The courageous response of many, especially at the community level, who are speaking out, mobilizing their neighbors and caring for those infected and affected by HIV/AIDS. Both the Secretary and I were moved by the compassion, courage and love demonstrated by community groups who are supporting infected persons and their families.
- The important work the United States, particularly USAID, is doing to prevent transmission, care for the sick and provide support to families and children affected by HIV/AIDS.

Let me share with you a few of the highlights of what I saw and heard:

In Kenya, I saw a wide array of HIV/AIDS prevention, care and support programs, which receive support from USAID. These range from HIV/AIDS community education through the Kenya Girl Guides to state of the art pilot programs to prevent mother-to-child transmission. I heard from one HIV positive mother of her need, and that of the women she counsels for family planning services and HIV/AIDS care and treatment. In Kenya, as well as elsewhere in Eastern and Southern Africa, the number of children who have lost one or both parents continues to grow rapidly. My visits to community-based projects, which care for orphans and families, convinced me that this is the most viable, humane and cost-effective way to help children. Faith-based organizations such as the Kenya Catholic Secretariat, Christian Health Association of Kenya and the Council of Imans play a critical role in enabling communities to take care of their own.

In Mali, I learned from my colleagues and our partners that we are not waiting until the epidemic is out of hand before acting. Working with national leaders in Mali, USAID is already helping providing edecision-makers with accurate information on the situation through its support for the first national population-based survey of HIV infection levels in the world and special policy-making presentations to key opinion-makers and leaders. Special education, reproductive health, and cross-border programs target youth and groups with high-risk behaviors. Acting now may spare Mali the tragedy of Southern and Eastern Africa. My discussions with religious leaders underscored the important role of faith-based organizations in mobilizing people for education, care and support. We will be working more closely with such leaders through a new Africa-wide initiative with faith-based organizations to get the word out through churches and mosques on how individuals can protect themselves and their families.

In South Africa, I visited an HIV/AIDS community care and support program, Hope Worldwide, in Soweto, the largest township in Africa. I heard from citizens of Soweto about how hard it is to be HIV positive in that community and the discrimination and poverty they face every day. USAID is helping HIV positive mothers to lessen the risk that they will pass on this terrible disease to their yet unborn infants through a pilot mother-to-child transmission prevention program. USAID

support links the Hope Worldwide Community Center to Baragwanath Hospital and ensures that mothers receive the follow-up and community support needed for them to protect their babies.

In Uganda, I gained new understanding of the human costs of HIV/AIDS as I listened to the personal testimony of widows with HIV/AIDS seeking to leave some legacy through memory books for their children, many of whom will soon be orphaned. Uganda's successes underscore both the importance of the longstanding partnership between the U.S. Government, the government of Uganda and Ugandan non-governmental organizations and of high-level and sustained political leadership in mobilizing public opinion as a basis for effective behavior change.

USAID is the lead U.S. agency at the country level. We have led the global fight against HIV/AIDS since 1986. We are the largest supporter of multilateral, bilateral and private non-governmental HIV/AIDS programs. We provide about 25 percent of the total funding for UNAIDS. We develop the U.S. HIV/AIDS country assistance programs that provide the framework for collaborative partnerships between the U.S., host countries, and other donors.

USAID is well positioned to play this critical leadership role because we have:

- on the ground country and technical expertise with recognized preeminence in reproductive health in developing and transitional countries.
- established relationships with other donors, U.S. private voluntary organizations and host country governments and private organizations.
- a tough minded, evidence-based approach which uses applied, field research to identify, test and demonstrate effective interventions to ensure that every dollar of USAID assistance counts.
- directly relevant experience from other development programs such as social marketing, mass media communication and peer education.
- successful ongoing HIV/AIDS programs which can be expanded rapidly or replicated to help more people.
- comprehensive country assistance programs which enable us to address HIV/AIDS from a national perspective and use multi-sectoral approaches to reach substantial populations and meet critical needs outside of the health sector.

USAID has made a difference in Africa and the rest of the world. We have:

- helped more than 35 million people protect themselves and their families through programs that have reached them directly with the ABCs of prevention: Abstinence, Be Faithful, and Condoms.
- increased world knowledge on the nature, magnitude and impact of the pandemic: We now know that no country is safe. Because of injected drug use, the former Soviet Union has the highest percentage HIV infection growth rate of any region in the world. Parts of the Caribbean and Central America are also experiencing very rapid increases in HIV infection. There is evidence that Asia will be the hardest hit region in the next decade.
- identified, tested and implemented pragmatic, field-tested approaches to HIV/AIDS prevention, care and support for orphans and other children affected by HIV/AIDS.
- shared U.S. expertise, resources and products. USAID is the largest supplier of condoms. Research in developing countries has shown that good quality condoms used consistently work well.
- leveraged other donor and private funding and other support. In Zambia, for example, a private South African firm, Sasol, which imports large quantities of fertilizer has printed an easy-to-read HIV prevention message on 800,000 fertilizer bags. The message reads:

> "To grow properly, your crops need fertilizer. To grow properly, your children need you. Use a Condom Every Time. Protect Yourself Against HIV/AIDS. Thank You. Maximum—Use it! Be wise, be Condom wise."

With the additional resources provided by Congress, we have adopted an expanded response which:

- focuses the majority of resources on four "rapid scale up" countries: Cambodia, Kenya, Uganda and Zambia, and 16 "intensive focus countries" to achieve greater results in critically affected countries.
- continues a strong focus on prevention. It is especially critical that we do a better job of reaching young people.

- provides more support for the care and treatment of those with HIV/AIDS, especially of the opportunistic infections such as tuberculosis which is the greatest cause of AIDS deaths in Africa.
- helps countries, communities and families deal more comprehensively with the consequences of the pandemic through special programs and multi-sector approaches such as community-based education, micro-credit and other help for families caring for orphans and other vulnerable children.
- improves our understanding of the epidemic and the impact of assistance through increased surveillance of the epidemic in key countries, tracking of HIV/AIDS related behavior and increased monitoring of USAID assistance impacts.

With the lives of millions at stake, it is critical that current and future programs are based on informed choices about the most effective and efficient ways to prevent transmission and to care for those affected. With the extra resources we are receiving, USAID can and will build on program successes like:

- partnerships with private organizations, such as those with faith-based organizations in Haiti and Kenya, which have provided critical information on HIV risk and prevention to parents and to youth. I came away from Africa with an increased awareness of the important role of faith-based organizations in mobilizing people for education, care and support activities.
- peer education and other targeted programs, which meet the needs of youth and special high-risk populations. Kenyan youth are using the stage to challenge HIV/AIDS myths and stigmas. There are now more than 270 youth theatre groups who have reached more than 400,000 people. In Jamaica, innovative theater groups are used to educate youth groups and parents in HIV prevention methods, including abstinence. In Russia, rock concerts are reaching thousands of at-risk youth with healthy life style messages. The South African "Lesedi" or "we have seen the light" project forms multi-sectoral partnerships between mining companies and health departments to provide education and treatment of sexually-transmitted infections to miners and other migrant workers at high risk of HIV infection.
- voluntary counseling and testing (VCT) programs, which provide individuals with the information they need to protect themselves and their families. A multi-site research study in Tanzania, Kenya and Trinidad and Tobago found that VCT reduced sexual risk behavior, especially in HIV positive persons. VCT also empowers HIV positive people. In the face of violence and discrimination, courageous people living with HIV/AIDS throughout India have built a national network to raise awareness, improve care and support for HIV-positive people and advocate for more enlightened, effective HIV/AIDS policies.
- social marketing programs, which make information and commodities widely available to citizens through private sector channels in more than 50 countries. In Kenya, monthly sales of the socially marketed condom, "Trust," total 1.2 million.
- technical assistance: USAID works with both governments and private groups to strengthen HIV/AIDS preventio n, care and support programs. In Brazil, USAID's HIV/AIDS program works at the state and national government levels to increase management capacity, improve efficiency and integrate detection and treatment methods into public health facilities.
- community-based care and support for people living with AIDS: In Cambodia, KHANA, the Khmer HIV/AIDS NGO alliance, which USAID supports, has piloted community home care teams. This approach reduces suffering, helps forge linkages between care and prevention and reduces discrimination against people living with AIDS. One widow explained how with the help of a KHANA Home Care Team, she was able to remain healthy, continue her business of selling food and keep her children in school.
- care and support for Orphans and Vulnerable Children: USAID is developing new community and family-based programs to help the 12 million children who have already been orphaned. In Uganda where there are now 1.7 million orphans, the Uganda Women's Effort to Save Orphans (UWESO) serves as an advocate for children's rights and supports activities to assist orphans and their families. With support from USAID and the Peace Corps, UWESO shifted its program emphasis from school fees and grants to micro-finance activities to provide an opportunity for income generation for households headed by widows, grandmothers, and a few children in addition to families providing

foster care for AIDS orphans. One legendary grandmother in her 70s, Bernadette, now cares for 31 grandchildren, three great grandchildren and four of her brother's children orphaned from AIDS, with the help of her daughter. Eleven of her 12 children have died of AIDS. She has successfully used and repaid three micro-finance loans and used the proceeds to launch two successful projects: one raising and selling pigs and the other buying and selling small fish in the market. The profits from these projects are used to support and pay schools fees for the children.

The job is not done. The challenge remains extraordinary, and so do our needs:

- *Resources:* Even with significant increases in U.S. support, total world financial and human resources allocated to date to HIV/AIDS are still inadequate to control the pandemic, heal the sick and care for those infected and affected. These limits have required USAID to set priorities, focus and concentrate our dollars and people in countries where the need is greatest and where USAID can make a difference.
  - — USAID continues to work with governments, media, private organizations and citizens to ensure that those at risk now have the knowledge and means to protect themselves and their families.
  - — USAID is pioneering and testing new approaches to care, prevention of mother-to-child transmission and help for orphans and other vulnerable children. We recently sent you reports on our work on mother-to-child transmission and on our help to orphans and other vulnerable children.
  - — USAID is working with other donors, other U.S. agencies, national governments and private organizations to identify and train more people.
  - — USAID, along with CDC and NIH, is supporting biomedical and operations research to develop affordable, feasible approaches. This includes research to develop a vaccine and microbicides to prevent HIV transmission.
- *Sustained Effort:* We are just at the beginning of a long battle which will determine the fates and well being of many of the world's citizens for the remainder of the century. Because of infections that have already happened, 44 million children in the 34 countries hardest hit by HIV/AIDS will have lost one or more parents by 2010. Still,
  - — Too few national leaders have stepped forward to take the actions needed to prevent an HIV/AIDS pandemic in their countries or to slow the epidemic already decimating their populations. We have seen in the Philippines, Senegal, Thailand and Uganda what a difference such leadership can make.
  - — Too much attention is paid in the world press to the anti-retroviral drug issue when an integrated strategy emphasizing prevention and including treatment and strengthened health care delivery is the only real answer to this crisis.
  - — Too few citizens know how to protect themselves and their children.
  - — Too few of those infected with HIV/AIDS receive even basic care not to mention anti-retroviral treatments, which could extend their lives. Many are shunned, abandoned and die prematurely in pain.
  - — Too many infected persons and their loved ones are stigmatized. This causes unnecessary suffering and makes prevention and care more difficult.
  - — Too few families and children affected by HIV/AIDS have the minimal essentials necessary for life and a future—food, shelter and a basic education. Children, often very young children, are trying to care for sick and dying parents and even their younger siblings.

I am determined, as the Administrator of USAID, that with your support we will meet this challenge. When we look back 10 years from now at our legacy, we will be able to say that the generosity and know-how of the American people made a difference and saved many from the worst epidemic in human history.

Chairman HYDE. Thank you very much, Mr. Natsios.

Mr. Lantos, we will do questioning now, all right?

Mr. LANTOS. Thank you very much, Mr. Chairman.

Mr. Natsios, I want to commend you for your presentation. There are so many questions on so many issues that I think I need to

focus on just one or two. And I want to underscore that the enormity of the crisis and the many faceted nature of the crisis must be an overwhelming experience for you because you have probably never faced anything of this scope. None of us have.

And I think I need to underscore that those of us who would like to see us do more are not engaged merely in a numbers game of asking for more for whatever reasons, but I would like to zero in on, in fact, absorptive capability and I would like to zero in on what, in fact, these numbers mean.

You made the point that the United States spends over 60 percent of all funds being spent on this disease. Am I correct?

Mr. NATSIOS. That is correct.

Mr. LANTOS. That certainly is a very impressive figure on a comparative scale, but the fact remains that if we are speaking of 275 million people when we spend $275 million on something, that is $1 a person, so that is really the meaningful criterion of our spending. A half a billion dollars, which I think is the broad overall proposal, is less than $1.70 per person in the United States. I mean, that is the scope of our spending, however generous it is.

Without first asking you what the absorptive capability would be, could we double spending, could we increase spending by 50 percent? USAID, as I understand it, has designated three African countries, Kenya, Uganda, and Zimbabwe, for a significant scale-up of HIV/AIDS programs. Is that correct?

Mr. NATSIOS. We have actually focused on 21 countries, but those three in particular because we started there earlier we were able to ramp up faster there.

Mr. LANTOS. Well, you are focusing on 21.

Mr. NATSIOS. Right.

Mr. LANTOS. But these three are moving more rapidly.

Mr. NATSIOS. That is correct.

Mr. LANTOS. Now, is the reason why others are not added to this list of three because they are incapable of absorbing more aid or is it because of inadequacy of funds?

Mr. NATSIOS. One of the problems we are facing——

Mr. LANTOS. Let me rephrase it.

Mr. NATSIOS. Yes.

Mr. LANTOS. If you had adequate funds, if you had twice what you now have, could you have designated six countries for a rapid scale up?

Mr. NATSIOS. Let me sort of put this in perspective. There are 50 countries in which we run—51, to be precise—HIV/AIDS programs. Twenty-one of them are on a substantial scale and three we are scaling up with some new pilots that were successful and therefore we are scaling those up. Every time we find an approach that works, we scale it up.

The problem in some countries is that the national leadership finds this an embarrassment. And I've had heads of state actually tell me that, you know, they have an unorthodox view. Some heads of state do not believe the HIV virus causes AIDS.

Mr. LANTOS. We know that, yes.

Mr. NATSIOS. That causes serious problems in the ministries because when we want to do certain things they say, wait a second, we cannot do that. So if we do not have the cooperation of the min-

istries of health and of the heads of state, it does put a serious constraint on what we are doing.

I met with the President of one East African country who is a very capable national leader and I said, "You know, your country has a serious problem."

And he said, "We do."

I said, "When did you decide to allow us to help you ratchet this up?"

He said, "Six months ago."

But this has been a problem there for 8 years. Now he is taking this very seriously and we are able to move it up. We have conversations with them, we talk with them, but there are some limits, political limits.

In the United States, we have gotten over the point of ostracizing people or viewing them as pariahs.

Mr. LANTOS. Yes, I understand what you are saying, but let me be specific. If you had the resources, could you scale up the AIDS program not in three countries, but in nine countries?

Mr. NATSIOS. We have in 21 countries. What I am saying is in those three countries, we have tried new pilots recently and we have scaled up in those countries because we tried them and they worked.

Mr. LANTOS. Well, attach some dollar figures. How much are we spending in Kenya?

Mr. NATSIOS. Kenya is $12 million.

Mr. LANTOS. Uganda?

Mr. NATSIOS. Uganda is 15.

Mr. LANTOS. And Zambia?

Mr. NATSIOS. Zambia is 12. Cambodia is the fourth one, that is 9 million.

Mr. LANTOS. That is 9 million?

Mr. NATSIOS. Yes. Another thing that I would mention, have you looked at Kofi Annan's budget figures?

Mr. LANTOS. Yes?

Mr. NATSIOS. It is 7 to 10 billion. Most of that is not for prevention programs, to stop the spread of disease. Fifty percent of it is for antiretrovirals. The problem with antiretrovirals for some of these countries is there are no roads or the roads are so poor it takes—I have been on many of them for 12 years—it is very difficult to get to the areas where the infection rates are.

Mr. LANTOS. I understand. I have just one more question because I think my time is running out.

You mentioned you have distributed, I believe, last year, 300 million condoms.

Mr. NATSIOS. Yes.

Mr. LANTOS. What was the sexually active male population in the countries where those condoms were distributed? What number of people are we dealing with?

Mr. NATSIOS. Up to 30 to 40 percent of males between 15 and 49 years old.

Mr. LANTOS. I need an absolute number. You have this figure that 300 million condoms, to how many people?

Mr. NATSIOS. I can get you that figure.

Mr. LANTOS. What is your ballpark estimate now?

Mr. NATSIOS. Between 50 to 75 million high risk males. In some Muslim countries in Africa, for example, you notice the statistics of the blue countries there in the north or the green countries? Because Islam is so pervasive, there is a much lower infection rate and that does affect people's behavior.

Mr. LANTOS. Yes, I understand that, but what you are saying, if you say 50 to 75 million, that is somewhere between four to six condoms per year per active male.

Mr. NATSIOS. Some men will not use——

Mr. LANTOS. That does not appear to be adequate.

Mr. NATSIOS. Right. The problem, Congressman, is that we cannot get, even in the United States, people to use condoms. We can encourage them, we can give them but we cannot force them to use them. And there is a portion of people in the United States we are now having trouble with. The infection rate, as you know, has gone back up again among at risk populations in this country and it is because people do not like to use condoms. Some people. So there is a portion of that population that simply will not use condoms. We can advertise, we can have the head of state talk, we can make them available, they will not use them.

And the other problem is the remoteness of some of the locations——

Mr. LANTOS. I understand all that, but are you suggesting the number of condoms you distributed last year is adequate for your needs?

Mr. NATSIOS. We need 3 billion condoms in Africa if we were to make complete coverage.

Mr. LANTOS. Ten times what you had.

Mr. NATSIOS. That is right.

Mr. LANTOS. Thank you, Mr. Chairman.

Chairman HYDE. The gentleman from California, Mr. Royce.

Mr. ROYCE. Thank you, Mr. Chairman. Thank you for holding these hearings. I do have some questions, but I think Mr. Houghton was next so I am going to allow you to recognize Mr. Houghton.

Chairman HYDE. Well, I like to work it by seniority on the Committee.

Mr. ROYCE. Mr. Chairman, I appreciate that.

Chairman HYDE. So we will have to get used to that.

Mr. ROYCE. I will ask my questions, then.

Chairman HYDE. Please.

Mr. ROYCE. Thank you, Mr. Chairman.

My first question would be what effect extending foster care to HIV orphans is having in Africa and whether particularly AID is involved in an effort to do that?

Mr. NATSIOS. We do not use the term foster care. That is more of an American term. It is simply adoption. Families adopt orphan children within the African tribal traditional quite readily. The problem is there are so many of them now that they are overburdening the tribal tradition and we are supplementing that with food. I think I announced before you came in, Congressman, that we just announced in Uganda a 5-year, $40 million food program that will direct food toward families that have adopted a number of HIV/AIDS orphan children because they cannot care for all of them at the same time.

Also, there are programs now—in some areas, we cannot find people to—where there are teenagers in the household—to take care of the kids, to adopt them. So what we do is we have community workers who go in and check on them every day, make sure they are cooking the food, they have adequate assistance. There is a community network that is being set up when that adoption system does not work. But there are community-based, home-based programs which are by far the most effective given the volume of people we are dealing with and given African tribal traditions which we want to be respectful of.

Mr. ROYCE. I have seen in countries like Uganda where President Museveni is really engaged in explaining the dangers of HIV and AIDS to the populous and in setting up a program of constant governmental information about it a very real difference in terms of the level of awareness versus other states like Zimbabwe.

What is the significance of political commitment by heads of state in Africa, by governments in Africa, in confronting HIV/AIDS?

Mr. NATSIOS. African society is very centralized, it is very hierarchical in the sense that people look toward strong leaders. I think it has something to do with tribal custom and structure of society. And so when a leader or head of state says there is a problem and says it over and over and over again, it has a real effect of focusing public attention, media attention, ministry attention on that problem. That is why the program has been so successful in Uganda and in other countries no matter we try to do, it has not been as successful because the heads of state are too embarrassed to talk about it.

Mr. ROYCE. Thank you.

Thank you, Mr. Chairman.

Chairman HYDE. Ms. Lee, the gentlelady from California.

Ms. LEE. Thank you, Mr. Chairman. Thank you very much for conducting these hearings.

Welcome. I am very happy to meet you. Let me ask you a couple of questions.

First, on the $200 million that the President announced as it relates to this international trust fund, could you explain the accounts that it is coming out of?

We have heard that it may be coming out of infectious disease, allergy control, or some of the accounts that I do not want to see attached. I think that we should look for new money, we certainly have it, $200 million is not adequate at all, but to take it from other programs does not make any sense.

Could you respond to that?

Secondly, I would like to ask you a little bit about the United Nations special session on AIDS. What exactly is the United States' position on it in terms of helping shape the declaration?

I have heard—it has only been rumors, but I have heard that USAID will not be participating because of vulnerable populations that are at issue with regard to the declaration.

Could you explain a little bit about our participation in the session and what our role is?

Mr. NATSIOS. In terms of the first question, where the $200 million is coming from, $100 million is coming from international trust

fund from HHS. I cannot tell you since I do not know their budget system at all or where it is coming from in their budget. You would have to ask them that.

Ms. LEE. But it is coming from HHS.

Mr. NATSIOS. That is correct. Another $20 million is coming out of our budget, but that money was already put there by the Congress——

Ms. LEE. That was last year.

Mr. NATSIOS. For a trust fund. No, this is for this year.

Ms. LEE. Well, okay. But it was put there.

Mr. NATSIOS. It was put there. It is appropriated, it was sitting in a reserve waiting for us to move it into this trust fund.

Ms. LEE. It was for the World Bank AIDS trust fund, I believe, which Congressman Leach and I worked on last year.

Mr. NATSIOS. That is correct.

Ms. LEE. Which he mentioned earlier.

Mr. NATSIOS. That is correct.

Ms. LEE. Okay.

Mr. NATSIOS. The rest of the money is coming out of a reserve in the State Department budget.

At the beginning, I have to be very candid with you, there were people who said, "That is fine for the $200 million, AID—find it out of your existing budget."

And I said, "Well, that is moving money from one group of poor people to another group of poor people."

And the person who stopped it was Colin Powell and the President. They said, no, no, no, no, that is not how we are doing this, find the money somewhere else.

And so we had a National Security Council meeting, their orders were pretty clear, and that is what happened. So I did not have to cut one dollar out of any existing budget in AID other than the money that was in these reserves that was specifically designated for these trust funds.

Now, the answer to your second question is we are participating at the technical level in the preparation for these U.N. meetings. We work with the U.N., with CDC, with other donor governments on a regular basis on these issues. There really is not a big impediment. And, frankly, there is a lot of political pressure on all of you and all of us at senior levels on this issue. But if you talk to the epidemiologists, the public health people, the people who actually work, it is pretty clear what we have to do. The problem is there are other options, other things that are being discussed which sometimes——

Ms. LEE. Right. Could you talk about what other things are being discussed so we can——

Mr. NATSIOS. Well, there is a big focus in Kofi Annan's paper on antiretrovirals. If the health care structure and systems exist in a country, they make sense—but in most of these countries, there are no systems, let alone modes systems.

For example, there is one doctor for 360 people in the United States. There is one doctor for 48,000 people in Mozambique. This is not like a shot or one pill once a year, like a Vitamin A therapy, you give it twice a year. A nurse could do that. These drugs are extremely toxic. Some people cannot take them and survive. Forty

percent of the people in the United States who are HIV positive do not take the drugs, many of them, because they get so sick from the drugs.

Ms. LEE. Okay. So what is the problem?

Mr. NATSIOS. So you have to have a physician administering the drugs and in many of these countries there are no physicians to administer. One. There are no roads. There is no cold chain——

Ms. LEE. Sure. But how does that relate to the declaration or the problems with regard to the special session?

Mr. NATSIOS. Because the debate is whether—how much of the proportion is to be used on those antiretrovirals versus on prevention, which is only 10 percent of what Kofi Annan's budget is about. Our budget is heavily invested in prevention.

Ms. LEE. I see. So there is a question with regard to——

Mr. NATSIOS. Strategy.

Ms. LEE [continuing]. Strategy.

Mr. NATSIOS. Yes.

Ms. LEE. And we are trying to work that out.

Mr. NATSIOS. We are trying to work it out. Clearly, the drugs that we give a woman at birth and the newborn at birth, they do work. You only have to administer it once and it has a profound effect.

Ms. LEE. Who is going to lead our delegation? Who will be leading the United States delegation?

Mr. NATSIOS. We are discussing that now, but it will be a very senior person. And AID is involved at the technical level.

Ms. LEE. Will you be attending?

Mr. NATSIOS. If they ask me to attend, I will attend.

Ms. LEE. You will be attending. Okay.

Thank you, Mr. Chairman, and if I get another chance, I would like to ask more questions.

Chairman HYDE. Well, we have five more witnesses, so I am pleading with the membership to be succinct.

And with that admonition, I recognize the white haired gentleman from Massachusetts, Mr. Delahunt.

Mr. DELAHUNT. The Chairman looks at me sometimes askance because I have served with the Chairman as one of his minions on the Judiciary Committee, so he knows there are moments when I tend to go on, but I always abide by his commands.

Let me just say this, to disagree for a moment with the Ranking Member who is no longer here, Mr. Natsios and I have some history together. We both served in the Massachusetts legislature. I come here today to not only ask a question or two, but also to welcome him. He is an outstanding appointment. And if anyone could deal with the Big Dig in Massachusetts, this prepares him well for the challenge that he meets as the director of AID.

Andy, welcome.

Mr. NATSIOS. Thank you.

Mr. DELAHUNT. I look forward to working with you.

Just to follow up with the questions that Congressman Lee was proposing, can you describe some of the absorption issues that AID faces? Because I think what I am hearing from you is that the lack of infrastructure for the disbursement of the appropriate medicines is so primitive that it makes sense at this point in time, while that

particular strategy by necessity is going to have to be more long-term in nature, that the efforts that AID and presumably this government's recommendation to the international community is an emphasis on the prevention because of its immediate results.

Can you just pick out some selected examples of the absorption problems that you are confronted with?

Mr. NATSIOS. The problem in many countries is that there is not a health care system that is comprehensive, the reaches whole populations. The great tragedy in this epidemic in terms of one country is Botswana. Botswana is one of the best managed countries in the developing world. There is almost no corruption. The ministries do their work very well. It has a 38 percent infection rate. And it is not because they do not have a good ministry of health, it is because there is a big mining sector and the miners are away from their wives for a large part of the year. That causes a lot of sex workers and that spreads the disease very rapidly in a country that actually has infrastructure.

So the biggest problem, if you look at Kofi Annan's budget, half the budget is for antiretrovirals. If we had them today, we could not distribute them. We could not administer the program because we do not have the doctors, we do not have the roads, we do not have the cold chain.

This sounds small and some people, if you have traveled to rural Africa you know this, this is not a criticism, just a different world. People do not know what watches and clocks are. They do not use western means for telling time. They use the sun. These drugs have to be administered during a certain sequence of time during the day and when you say take it at 10:00, people will say what do you mean by 10:00? They do not use those terms in the villages to describe time. They describe the morning and the afternoon and the evening. So that is a problem.

The problem of clean water is an issue in many areas. So the focus that we and other donor governments have taken at the technical level and the NGO level have been focused on prevention. First, because we have the drive and we have the absorptive capacity. The ministries of health that do have some infrastructure through their clinical workers—radio stations, for example, are very effective means for getting the word out, posters and radio stations, because people in very remote areas have radios and they listen in the villages. I have been there when they have played them in the evening. So that is a very powerful weapon to stop the spread of the disease.

The biggest problem on the infrastructure side is the administration of drugs which have to be administered daily and kept frozen and all that. The drugs for tuberculosis and those for malaria, those are much easier for us to administer than the antiretrovirals would require. So there is a focus in our program on treating the opportunistic diseases that lead to death.

Most people do not die of HIV per se, they die of a disease because their immune system is collapsed, as I am sure you know, Congressman.

Chairman HYDE. The gentleman's time has expired.

Ms. Davis, do you have any questions?

Ms. DAVIS. Yes, Mr. Chairman. Thank you so much for holding this hearing.

And thank you, Mr. Natsios.

I would like to know, we have talked about HIV. Is HPV a problem in Africa?

Mr. NATSIOS. We have Dr. Delay here who will answer the question.

Dr. DELAY. Human papilloma virus is a major problem in Sub-Saharan Africa and in many parts of the world. The thing that is most concerning is that it is one of the major factors that causes cervical cancer and cervical cancer is a very prevalent cancer in Sub-Saharan Africa.

Ms. DAVIS. Given that, then, with respect to the condom distribution, what effort have USAID made to educate Africans that condoms do not protect against the HPV?

Dr. DELAY. To be quite honest, not a lot. Condoms do not protect against HPV completely, nor herpes, which are the two viruses that are not in the actual bodily fluids, where it can be a skin-to-skin contact. Most of our programs do not talk about HPV, primarily to not make the messages too complicated. Also, understanding of what HPV is very limited. It is not a term that people know.

Ms. DAVIS. So they may have a false sense of security if they are using these 300 million condoms and think they are perfectly safe when in fact they may not be, but there is no warning that there is a problem or possibility.

Mr. NATSIOS. Our two preferred strategies before condoms, and I say this very seriously, are abstinence and faithfulness. It has changed the social structure in many African countries. There are people who do not get married now deliberately and will be abstinent their entire lives because they know the risk of infection is so high that they may die. And so I have met many people in Africa who have made a decision and those strategies are very powerful and they do work and they work particularly among young women. We have noticed a dramatic drop in the infection rates when we do that. And, of course, once that happens, there is protection against those other diseases as well.

Ms. DAVIS. Just real quick, Mr. Chairman, do you have the cervical cancer rate in Africa?

Dr. DELAY. I could get that number for you. I believe it is about 500,000 deaths per year caused by cervical cancer, but I will need to check that.

Ms. DAVIS. Thank you, Mr. Chairman.

Chairman HYDE. Well, unfortunately, we have a vote and we have five more witnesses, so I am going to recess the Committee. Let us come back at 1 and ask the other witnesses if they want to grab a sandwich of something similar. We will resume at 1 and we will try to finish up.

Is that acceptable to you, Mr. Natsios?

Mr. NATSIOS. It is. Do you want me to be back at 1 or are you going to go on with the other witnesses?

Chairman HYDE. No, I think we can dispense with your——

Mr. NATSIOS. You can dispense with me.

Chairman HYDE. Yes. You have been——

Mr. NATSIOS. I appreciate that, Mr. Chairman. Thank you.

Chairman HYDE. Thank you very much.

[Recess.]

Chairman HYDE. The Chair announces that pursuant to our rules we need two Members to take testimony and we have waited a sufficient time. I am reluctant to impose on our witnesses any more and so I am going to flaunt the rules and proceed.

Your statements will be made a part of the record, but you are here and we would like to hear you testify and so we will begin on our second panel.

We have the distinguished Ambassador from Senegal General Mamadou Mansour Seck. He holds considerable influence as the Dean of the West African Diplomatic Corps and has worked closely with the U.S. Departments of State and Defense in the design phase of the African Crisis Response Initiative and the African Center for Strategic Studies.

Prior to his appointment 9 years ago, Ambassador Seck was General Chief of Staff, Chairman of the Joint Chiefs of Staff, of Senegal.

It is an honor to welcome the Dean of the West African Diplomatic Corps.

Thank you, Mr. Ambassador.

Also joining us today is Stephen Hayes, currently President of the Corporate Council on Africa. From 1996 to 1999, he served as North American Director for Winnington Limited of London. Mr. Hayes was President of the American Center for International Leadership and has chaired and directed over 30 international conferences.

Mr. Rupert Scofield is Co-Founder and Executive Director for Foundation for International Community Assistance (FINCA). He has previously held positions as CEO of Rural and Development Services and Country Program Director for AFL–CIO's Labor Program in El Salvador. Mr. Scofield, is a renowned expert on microfinancing and has designed innovative programs to assist the poor economically while enduring challenges, such as the HIV/AIDS pandemic.

Mr. Charles L. Dokmo has served as President of Opportunity International for the last 3 years. From 1994–1997, he was Regional Director of World Vision, Bucharest, Romania and has 20 years of experience with international non-governmental organizations. He is a pioneer in the micro-finance field and has dedicated his entire life to helping those in need. It's an honor to have Mr. Dokmo testify before the Committee.

Dr. Paul Zeitz is the founder and co-director of Global AIDS Alliance. He is a medical doctor with a specialization in international public health and epidemiology and holds a Master of Public Health from Johns Hopkins University School of Hygiene and Public Health.

Dr. Zeitz has served as Intercountry Coordinator for the U.N. Special Program Against HIV/AIDS Intercountry Coordinator for Eastern and Southern Africa and as Senior Policy and Technical Advisor for HIV/AIDS, Population, Child Health and Nutrition, Government of the Republic of Zambia, and USAID/Zambia. Dr.

Zeitz is a dedicated professional and a leading advocate for those afflicted with HIV/AIDS.

We welcome the insights you gentlemen today offer and ask that you proceed with a 5 minute summary of your written statements. Your complete statements will be made a part of the record.

We will begin with Ambassador Seck.

STATEMENT OF HIS EXCELLENCY MAMADOU MANSOUR SECK, AMBASSADOR E&P, REPUBLIC OF SENEGAL

Ambassador SECK. Mr. Chairman, good afternoon and thank you.

Ladies and gentlemen, Members of the House Committee on International Relations, thank you for your interest in Africa. I have to apologize because in my country we speak in French, so if you do not understand my English, I have to apologize in advance.

Ladies and gentlemen, Mr. Chairman, you highlight all those staggering numbers about HIV/AIDS all over the world. Those numbers, 35 million in the world and among them 26 in Africa infected; 11 million orphan children are living in this world. So 15,000 people are dying, as newly infected among them 5000 in Africa.

Even in this country with the high tech and the resources, still more than 1 million were infected for the last 20 years and a half million died. This means it is a global threat.

Of course, Africa is at the forefront of the fight. Last week, we read that a very young man, 12 years old, Nkosi Johnson, died. He was 12 years old. He was the hero of the International Conference on AIDS in Durban, South Africa—South Africa, where there are the highest number of infected, almost 5 million people.

Ladies and gentlemen, what is the story of Senegal in this context? Sometimes when we talk about HIV/AIDS or assistance, we have the impression that there is nothing in Africa, there is no expert, we are not doing anything, but I think the burden is on the Africa shoulders first. Of course, we are friends to the Americans and we want them to be on board of this global pandemic because America, like Senegal, is a democracy.

That means that we cannot close our borders. Even in the case of Senegal, if we talk about the success stories, we still cannot close our border. If we have one of the lowest prevalences, still we are in bodies and institutions like the Economic Cooperation of West African States (ECOWAS) countries in West Africa where we have the free circulation of service and persons.

What happened in Senegal? In 1969, Senegal already started the registration and regular medical checkups of sex workers. Prostitution was legalized. In 1969, we began the blood bank testing. In 1986, the government designed the Plan National De-Lutte-Contre-Le-SIDA, National Plan to Fight HIV/AIDS. In 1992, Senegal was the driving force behind the Declaration of the Organization of African Unity, the body, the African body for the continent.

Now we have 80,000 cases of HIV in Senegal. That means a prevalence of 1.5 percent, when we know that in Eastern Africa or Southern Africa they have 10, 20, even 30 percent of prevalence.

What are the enabling factors?

Number one, the conservative, cultural, and traditional norms regarding sex. For example, universal circumcision and lack of con-

sumption of alcohol because we are mostly Muslim, 95 percent Muslim, 4 percent Christian.

In 1997, a study reported that 68 percent of the women stated they had no sex before their marriage; 10 percent of men said the same thing. Marriage is late in life, 20–25 years old. Even if these numbers seem to be high sometimes, due to our culture and our religion, abstinence and fidelity remain strong values in our families.

Number two, information, education, and prevention. We targeted high-risk workers, prostitutes, and fishermen because in our country it is a very large practice for fishing, truckdrivers, soldiers, migrant workers, et cetera.

Number three, early active commitment of the political, religious, and community leaders. At the beginning, it was not very easy to talk to the religious leaders because speaking about sex, about privacy, about condoms, means that you allow sex outside of marriage. It was difficult in the beginning, but when we demonstrated in other parts of Africa that the prevalence is double digit—10 percent, 20 percent—we convince people and religious leaders to be even our advocate for our national plan.

Number four, the promotion of condom use. Once people were convinced, especially those leaders, we transformed our practice. Only 1 million condoms used to be sold in Senegal but now we sell or use 10 million for a population of 10 million people. That means that openly we can use it for prevention.

Number five, monitoring the prevalence and managing sexually transmitted diseases.

Number six, international cooperation. I stress that this is where we have our own experts. Our national team, the medical team led by Professor Mboup and Dr. Ndoye worked with their international counterparts, especially the Center for Disease Control (CDC) in Atlanta and also the School of Medicine of Harvard University in Massachusetts. This team was apart of the discovery of the virus number 2 that you find only in Western Africa.

What was the involvement of USAID in my country and in Africa in general?

USAID provided 57 percent of the donations received by Senegal since 1994. That means $20 million. The European Union provided 25 percent. USAID intervened at three levels: national, central, and community level.

First, prevention. Consistent with our national plan, the agency targeted the high-risk groups, particularly the mobile populations and the students, by counselling them and promoting the use of condoms.

Number two, policy dialogue: Information dissemination, decentralization at the community level, the religious level, and the political level. Also, preparation of meetings of decision-makers like the recent maintenance technician in Abuja, Nigeria.

Number three, capacity building. Monitoring, evaluating and training.

Number four, distribution of condoms free of charge to the high-risk groups, STD patients, and educators.

Number five, communication for behavior change, mainly through NGOs and the mass media.

In total, USAID plans to contribute $143 million for Africa for the fiscal year 2001 specifically in prevention, support for orphans and vulnerable children, and for care and support for individuals living with HIV/AIDS.

Uganda, Senegal, Zambia specifically benefitted from AID intervention. The assistance of AID is critical not only for countries where we can talk about relatively successful stories, but also in the heavily infected countries like Southern Africa and Eastern Africa.

I conclude by the hope for our common future. The global epidemic can be overcome, Mr. President. HIV, like international terrorism, narcotic trafficking, global warming, money laundering, is a global threat to our common humanity. One nation, even a superpower, cannot fight them alone and succeed.

We are living in a global village. We all are neighbors and interdependent. Isolation is not possible any more.

In the case of HIV, the continent of Africa, of course, is the first to confront the threat; but ladies and gentlemen, our children, your children, could be married to an individual from another continent. For example, they could attend the same university—a foreigner could become a part of your family overnight. This is why we must fight this global threat together. In this country, even in the U.S., there is no eradication and there is not yet a vaccine.

The leadership of this Nation, the United States of America, champion of democracy and freedom, should not be only about technology, the economy, missile defense and the like—but also about human rights and justice of our common humanity.

As you know, leadership is not cheap. When the triple therapy of HIV drugs costs more than $10,000 in the U.S. and could be discounted to $600, there is still a gap of $200. We hope that the Global Fund promoted by Kofi Annan, Secretary General of the U.N., will help. President Bush promised $200 million of contribution. What is needed is $8 billion.

At the same time, the international community is spending $3 to 4 billion a day for military purposes, 10 years, 12 years after the end of the Cold War. One solution would be just to divert 4 days of military spending to solve that problem. As a former soldier, I know that we can manage it.

Also, the pharmaceutical companies could accept the distribution of earmarked, discounted drugs for Africa during this decade. The sales of drugs in Africa represent only 1.3 percent of the total.

The World Bank is engaged in the MAP Program for $500 million.

The USAID has an extensive knowledge of the environment on the ground. Its experience is unique in Africa at the grassroots level. With the necessary funding, we are confident that the agency can bring a significant contribution to this fight.

Mr. Chairman, I will paraphrase you before concluding. You said 2 days ago during the embassy luncheon that we attended that we all are our brothers' keepers. We all are our brothers' keepers. I thank you very much for your time. Thank you.

[The prepared statement of Ambassador Seck follows:]

PREPARED STATEMENT OF HIS EXCELLENCY MAMADOU MANSOUR SECK, AMBASSADOR E&P, REPUBLIC OF SENEGAL

Mr. Chairman, ladies and gentlemen, members of the House Committee on International Relations, as the Ambassador of Senegal, I am honored and pleased to bring an African voice to the debate on HIV/AIDS and I thank you, Mr. Chairman, for inviting me on this occasion.

HIV/AIDS : THE CASE OF SENEGAL AND USAID SUPPORT

I. A Global Threat

I am sure that, ladies and gentlemen, you all are familiar with these striking figures.

- *Worldwide*—There are 36 million people infected with HIV and among them, 26 million are Sub-Saharan Africans. There are 11 million orphaned children and 95% of them are living in developing countries.
- *Africa*—45% of the infected are men, 55% are women, and they are infected by heterosexual encounters.
- *USA*—90% of the infected are men (predominantly homosexuals) and 10% are women. Among the more than 1 million Americans infected since the 80's: 450,000 have died. Last week, the Washington Post highlighted the rise of HIV in young gay men. The Centers for Disease Control reported that 32% of Black gay men are infected by HIV in six major cities in the United States.
- *South Africa*—Has the largest HIV infected population, 4.7 million, 12% of the global total.

A young South African, *Nkosi Johnson*, was killed last Friday by the disease. He battled for all of his 12 years. He earned his reputation as an outspoken representative of the millions of infected Africans during the International AIDS Conference in Durban, South Africa last July.

II. Senegal's Success Story

A. The Turning Points

1. In 1969, Senegal started the registration and regular medical check-ups on sex workers. Prostitution was legalized.
2. In 1970, we began blood bank testing.
3. In 1986, the government designed the *Plan National De-Lutte-Contre-Le-SIDA* (National Plan to Fight HIV/AIDS).
4. In 1992, Senegal was the driving force behind the Declaration on HIV/AIDS by the Organization of African Unity.
5. Now, 80,000 cases of HIV are reported in a population of 10 million. This means a prevalence of 1.5%.

B. The Enabling Factors

1. The conservative, cultural and traditional norms regarding sex:
   - universal circumcisions
   - low alcohol consumption (95% are Muslims, 4% Christians)
   - In 1997, a study reported that 99% of the married women said they had not had extra-marital sex. 80% of the men reported the same. 68% of women stated they had not had sex before marriage. 10% of men reported the same. 1As you can see, due to our culture and strong religion, people practice the rules of *abstinence and fidelity.*
2. Information, education and prevention: We targeted high-risk workers, prostitutes, fisherman, truck drivers, soldiers, migrant workers, etc.
3. Early active commitment of the political, religious and community leaders: In the beginning, they were opposed to any information about sex. But, the religious leaders, once convinced, became strong advocates of our National Plan (speaking openly about sex and condoms meant accepting sex outside of marriage).
4. Promotion of condom use: Twenty years ago less than I million condoms were used. Now, more than 10 million are openly distributed.
5. Monitoring the sero-prevalence and managing the sexually transmitted diseases *(STDs).*

6. International cooperation and exchange: Our national medical team led by Professor Mboup and Dr. Ndoye worked with their international counterparts in the Center for Disease Control in Atlanta and Harvard University Medical School.

III. USAID Involvement and Support

USAID provided 57% of the donations received by Senegal since 1994 ($20 million). The European Union, France included, provided 25%. USAID intervened at three levels: national, central and community.

A. Prevention: Consistent with our National Plan, the agency targeted the high-risk groups, particularly the mobile populations and the students, by counseling them and promoting the use of condoms.

B. Policy Dialogue: Information dissemination, de-centralization at community, religious and political levels, and preparation of meetings of decision-makers *(ABUJA, NIGERIA).*

C. Capacity Building: Monitoring, evaluation and training.

D. Distributions of condoms free of charge to the high-risk groups, STD patients and educators.

E. Communication for behavior change, mainly through NGOs and the mass media, didactic materials, etc.

In total, USAID plans to contribute $143 million to Africa for HIV/AIDS for fiscal year 2001, specifically, in prevention, in support for orphans and vulnerable children, for care and support, for individuals living with HIV/AIDS.

Senegal, Uganda and Zambia specially benefited from USAID intervention, which contributed to their successful HIV policy.

The assistance of USAID is critical, not only for countries like Senegal and Uganda, but, also for the heavily infected countries in Southern and Eastern Africa.

IV. Hope For Our Common Future

HIV/AIDS like international terrorism, narcotic trafficking, global warming, money laundering are global threats to our international community. One nation, even a superpower, can not fight them alone and succeed.

Ladies and gentlemen, we are living in a global village, we all are neighbors and interdependent. Isolation is not possible anymore.

In the case of HIV/AIDS, the continent of Africa is the first to confront the threat, but, *ladies and gentlemen*, your children, my children could be married to an individual from another continent because they share the same university for example. And a foreigner could become a part of our family overnight. This is why we must fight this global threat together. In this country, there is no eradication of the disease and the vaccine is not found yet.

Ladies and Gentlemen, the leadership of this great nation, champion of democracy and freedom, should not only be about technology, economy, missile defense and the like; but also, about human rights and justice in our common humanity. As you know, leadership is not cheap.

When the triple therapy of the HIV drugs cost more than $10,000 in the US and could be discounted to $600, there is still a gap of some $200 between the cost and the average income per capita in Africa. The *Global Fund* promoted by Mr. Kofi Annan, Secretary General of the United Nations is an approach. President Bush was generous in promising $200 million of contributions in the $8 billion needed. At the same time, the international community is spending $2 to $3 billion a day for military purposes 12 years after the end of the *Cold War*. One solution could be to divert four days of military spending to finance the *Global Fund* and solve the HIV problem for our common humanity.

Also, the pharmaceutical companies could accept the distribution of earmarked, discounted drugs for Africa during this decade. The sales of drugs in Africa represent only 1.3 percent of the total.

The *World Bank*, in relation with the U.N., recognizes the magnitude of the threat and has announced its commitment in the fight by designing the *MAP Program* of $500 million.

The USAID has the knowledge of the environment on the ground. Its experience is unique in Africa on the grassroots level. With the necessary funding, we are confident that the Agency can bring a huge contribution to the success of our struggle.

Mr. Chairman, ladies and gentlemen, thank you for your attention.

Mr. SMITH [presiding]. Ambassador Seck, thank you very much for your testimony.

We are going to proceed with the testimony from each of our distinguished panelists and then go to some questions from Members of the Committee.

I thank you for that very fine testimony.

I would like to ask Mr. Hayes if he would proceed with his testimony.

STATEMENT OF STEPHEN HAYES, PRESIDENT, CORPORATE COUNCIL ON AFRICA

Mr. HAYES. Thank you, Mr. Chairman, and distinguished Members of the Committee.

I would like to in my brief remarks talk about the economic consequences to not only Africa but American businesses; briefly describe some roles for the corporate sector; and underline the important point that Ambassador Seck has made that we all have to work together, we have to find ways to come together or this problem is not going to be defeated.

I want to thank you for holding this hearing on one of the gravest threats humanity faces today, and I want to applaud the Chairman and Members of the Committee for enabling legislation that will empower USAID to work with organizations like the Corporate Council on Africa to prevent, treat, and monitor HIV/AIDS in Sub-Saharan Africa and other developing countries.

The problem of HIV/AIDS is having a profound negative impact on American business in Africa. American companies are looking to Africa as a critical new market. The U.S. already trades more with Africa than it does Russia, the newly independent states and Eastern Europe combined. The population of Africa represents a market nearly as large as China or India.

It has also been estimated that the continent will be supplying 20 percent of American energy needs by the year 2010 and already two-way trade is $40 billion between Africa and the United States.

Although the bulk of U.S. investment and trade have historically been oil and gas related, investments in telecommunications, agribusiness, textiles, infrastructure, technology and transportation have been increasing significantly. I note these to understand the growing economic importance of Africa to the U.S. economy.

Increased investment in Africa helps the U.S. economy as much as it helps the economies of African nations. Therefore, in addition to desiring to alleviate the sheer human misery of one of the great plagues of humanity, businesses are affected by increased costs of operations due to health care related to AIDS, absenteeism, burial fees, employment recruitment, training and retraining in Africa.

HIV/AIDS is also threatening development all across the continent, the economies, the workforces, the businesses, the workers, the families, and for that reason we are very deeply concerned about the HIV/AIDS spread in Africa.

One study shows that the infection rate of 20 percent or higher of the adult population translates into negative economic growth for a nation without exception. We already have several nations at that level.

The Corporate Council, the 170 members that make up 85 percent of total U.S. private investment in Africa, believes that the overriding priority for responding to these problems should include

education and prevention and treatment programs, just as Ambassador Seck has said.

We believe that educating the workforce about HIV/AIDS and effective prevention programs would cost American corporations considerably less by dealing with the issues now then dealing directly with the consequences of an AIDS-infected workforce. As grave as the problem is, Africa continues to offer expanding opportunities for investment from U.S. businesses.

Mr. Chairman, no sector of life has all the answers to the problems of AIDS. The corporate sector certainly does not. It recognizes the seriousness of the issue and I believe many corporations are doing outstanding work on the issue. To battle HIV/AIDS will require cooperation and support from every sector of society. It also obviously means that corporations have to be more aware of what each other is doing and we are finding in our work that that is not the case yet.

American businesses are providing leadership in this issue already, as we know. We would welcome the opportunity to work more closely with USAID and other branches and we also are expanding and building models for the corporate sector.

Very briefly, to assist our members, we have formed a task force on HIV/AIDS. That report will be issued to the public next month. We have charged the task force with exploring the problem and to develop an approach to combat the disease that would be supportive and helpful to the populous and the American industry engaged in Africa.

The goal we set was to develop appropriate best practices and recommendations that would result in effective and affordable ways that the Corporate Council and its members could maximize their ability to deal with their industrial problems, to maintain investment in Africa and actually to increase that investment, as well as to assist in combatting the disease.

Very briefly, the task force report will focus on eight case studies of best practices that corporations are now engaged in in Africa. They will present a clear awareness of HIV/AIDS as a business issue which affects medical costs, labor, and investment. It will direct members to available resources. We are finding that corporations are not aware of a lot of this.

Fourth, while providing a list of guiding principles drawn from best practices, the report will emphasize that one size does not fit all, there are many ways to address the problem and we have to work together.

Fifth, the task force addresses the need for funding and contributions from the private sector. It simply must happen. Partnerships with government and other private sector organizations are strongly emphasized.

Africa is a rich, vital continent with resources that are of benefit to the entire world. In order for the world and Africa to benefit, industry must be committed to looking at its own practices and determining how they might complement other ongoing efforts. Collaboration among industry itself, with government and other nongovernmental groups, is absolutely essential. We simply must not fight one another.

It is our hope that some of the data, the case studies and best practices included will serve as a stimulus for increased efforts on all fronts. This especially includes cooperation with USAID efforts to fight HIV/AIDS.

Again, thank you, Mr. Chairman, for the opportunity.

[The prepared statement of Mr. Hayes follows:]

PREPARED STATEMENT OF STEPHEN HAYES, PRESIDENT, CORPORATE COUNCIL ON AFRICA

Mr. Chairman and Distinguished Members of the Committee:

I want to thank you for holding this hearing on one of the gravest threats humanity faces today. I also want to applaud you, Mr. Chairman and other members of this committee for this enabling legislation that will empower USAID to work with organizations like the Corporate Council on Africa to prevent, treat and monitor HIV/AIDS in sub-Saharan Africa and other developing countries.

The problem of HIV/AIDS is having a profound negative impact on American businesses in Africa. American companies are looking to Africa as a critical new market. The United States already trades more with Africa than it does with Russia, the Newly Independent States and Eastern Europe combined. The population of Africa represents a market nearly as large as China or India. It has also been estimated that the continent will be supplying 20 percent of American oil needs by the year 2010. Already two-way trade between Africa and the United States is almost $40 billion. Although the bulk of US investment and trade have historically been oil and gas sector-related, investments in telecommunications, agribusiness, textiles, infrastructure, technology and transportation have begun to increase significantly. I note these few statistics so that you will understand the growing economic importance of Africa to the American economy. Increased investment in Africa can help the American economy as much as it can help the economies of the African nations.

In addition to desiring to alleviate the sheer human misery of one of the great plagues on humanity, businesses are also affected by increased costs of operations due to health care, absenteeism, burial fees, employee recruitment, training and retraining. HIV/AIDS is also threatening development all across Africa—affecting economies, workforces, businesses, workers and their families. For these reasons, we are deeply concerned by the spread of HIV/AIDS in Africa. One study shows that an infection rate of 20 percent or higher in the adult population translates into negative economic growth of a nation. Some countries have already surpassed this rate.

We at the Corporate Council on Africa, whose more than 170 members make up nearly 85 percent of total American private sector investments in Africa, believe that the overriding priority for responding to these problems should include education, prevention and treatment programs. We believe that educating the workforce about HIV/AIDS and effective prevention programs will cost American corporations considerably less than dealing with the consequences of an AIDS-infected workforce. As grave as this problem is, Africa continues to offer expanding opportunities for business investment and profit.

Mr. Chairman, no sector of life yet has all the answers to the problem of AIDS. The corporate sector does recognize the seriousness of the issue, and I believe many corporations are doing outstanding work on the issue. To battle HIV/AIDS will require cooperation and support from every sector of society.

American businesses are providing leadership already in this crisis. We would welcome the opportunity to work more closely with US AID and other branches of the US Government and international community. The Corporate Council on Africa has decided to build on and expand models already being used by our members.

To assist our members and other potential investors in Africa in addressing the crisis, we formed a Task Force on HIV/AIDS in Africa early last year. We charged the Task Force with exploring the devastating problem of HIV/AIDS in Africa and to develop an approach to combat this disease that would be helpful to the populace and to the American industry engaged in Africa. The goal we set for the Task Force was to develop appropriate 'best practices' and recommendations that would result in effective and affordable ways that the Corporate Council and its members could maximize their ability to deal with their industrial problems as well as assist others in combating the massive and complex problems caused by AIDS.

The Task Force Report, which will be released early next month, will include several important elements. First, nine case studies have been included from which corporate leaders can draw 'best practices' and determine do's and don't's.

Second, Task Force members should present a clear awareness of HIV/AIDS as a business issue, which affects medical costs, labor and investment.

Third, the report will direct members to available resources.

Fourth, while providing a list of guiding principles drawn from the best practices, the report will emphasize that "one size does not fit all."

Fifth, the Task Force addresses the need for funding and the contribution the private sector must make. Partnerships with government and other private sector organizations are emphasized.

Africa is a rich, vital continent with resources that are of benefit to the entire world. In order for the world and Africa to benefit, industry must be committed to looking at its own practices and determining how they might complement other ongoing efforts. Collaboration among industry, with government and other non-government groups is essential for success. It is our hope that some of the data, case studies, and the best practices included in our Task Force report will serve as a stimulus for increased efforts on all fronts. This includes cooperation with and support of US AID efforts to fight HIV/AIDS.

Again, thank you Mr. Chairman for this opportunity to appear before you. I will be happy to respond to any questions.

Mr. SMITH. Mr. Hayes, thank you very much for your excellent testimony.

The Chair recognizes Mr. Scofield.

STATEMENT OF RUPERT SCOFIELD, EXECUTIVE DIRECTOR, FOUNDATION FOR INTERNATIONAL COMMUNITY ASSISTANCE

Mr. SCOFIELD. Thank you, Mr. Chairman, for the opportunity to address the Committee on this important issue.

FINCA International is a global microfinance intermediary providing over $60 million in loans annually to 175,000 poor clients through our worldwide network of 10,000 village banks in Latin America, Africa, and Asia. Ninety-four percent of our clients are women and over 68,000 of these reside in Africa where we have worked for 10 years. By the year 2005, we hope to reach 500,000 active clients worldwide.

I would like to begin today with the story of one of our clients in Africa.

Ramulati Kibrige, a baker, cares for 15 children left orphaned after her two sisters and her 22-year old daughter died of AIDS. With her first FINCA loan of $35, financed through a grant from USAID, for the first time Ramulati was able to buy flour and sugar in bulk, allowing her to take advantage of wholesale prices to generate larger profits. With on-time payments and successive loans, she has been able to increase her production and profits in her bakery to meet the daily nutritional needs of her family and pay the children's school fees.

Ramulati says the success of her business and her participation in the FINCA program has given her more than an income. "Now I have no fear," she says.

Despite the sadness and struggle AIDS has brought into her life, Ramulati remains optimistic. "Because I am working, we are happy in our home," she says.

Due to the AIDS epidemic, FINCA and its clients face unique challenges in Africa. Among the hardships faced by our clients are the burdens of additional health care costs, burial costs, the cost to support victims of AIDS, and, of course, the emotional pain of losing loved ones from this dreaded disease.

In Uganda, over 80 percent of FINCA's clients are currently caring for and providing financial support to children orphaned by AIDS. Given this daunting operating environment, FINCA has been faced with a choice to limit our risk and operations in Africa

or meet the challenge of AIDS head on and adapt our programs in such a way to help both our clients and our institutions survive. We have chosen the later course.

Our response to AIDS in Africa is built on three pillars. The first is helping communities devastated by AIDS create an economic and social safety net through FINCA's core financial products. By sapping vital economic and social resources, the AIDS crisis creates a downward spiral that affects the entire community and can push families into complete destitution.

FINCA's goal is to reverse this downward spiral by creating the necessary economic and social backbone to weather the negative impact of AIDS on the communities.

A critical dimension of this is the empowering effect microcredit gives to women, giving them the economic power to avoid sexually exploitative relationships.

The second pillar of our approach involves innovating new financial products to help households and institutions mitigate the economic risks of the AIDS crisis. To provide an additional measure of economic stability to the clients, FINCA has been experimenting with new financial products such as credit and health insurance.

In Uganda, FINCA offers credit and life insurance through a unique partnership with a formal sector insurer, AIG. The insurance pays the balance of a group member's loan in case of her death or disability for any reason, including AIDS, taking the burden off the other members of her village banking group.

In collaboration with local hospitals and a U.S.-based HMO, FINCA Uganda is experimenting with a health care insurance program through which FINCA's clients have easy and affordable access to health care. For a modest premium, a family can be covered for preventive, primary and limited acute care. Although the benefits do not include direct AIDS treatment, it does provide treatment for many AIDS-related illnesses.

The third pillar of our approach involves disseminating health education and services through alliances with health organizations. FINCA's village banking infrastructure provides a distribution channel for a variety of financial and nonfinancial services. FINCA's clients assemble weekly to process loan payments and collect savings. Their weekly village bank meetings provide an opportunity for AIDS education.

We have utilized two approaches here. First, partnering with AIDS education and prevention agencies to provide this training and, second, getting training for our credit officers in the provision of information on HIV/AIDS. Among the lessons we have learned is that the client's time is very valuable and in order to be effective, AIDS education programs must be delivered in an efficient and succinct manner.

I would like to make some recommendations to the Committee. As the Committee considers this legislation, FINCA would suggest laying out a global AIDS initiative, including the following two components:

First, interventions that help communities prevent infection and care for victims and orphans of the disease.

Second, interventions like microenterprise development that raise the income and status of women. If empowered, these women

can stand as a powerful social force to fight the spread of the disease.

From the vantage point of a microfinance institution, we suggest that the package include the following principles:

First, health and microfinance institutions should be supported to develop partnerships for providing comprehensive support services to communities devastated by AIDS, including preventive education, microenterprise development and health care.

Second, in order to have an impact commensurate with the scope of the crisis, health and microenterprise institutions should use service delivery models that are scalable. When possible, they should be structured on a cost recovery basis so that scarce program resources are multiplied and leveraged with private sector capital.

Microenterprise institutions should strive to serve both HIV negative and HIV positive clients. They should avoid creating incentives to incentives to exclude HIV positive clients, while using credit insurance to mitigate risk. If known, the status of these clients in terms of AIDS should be maintained in the strictest confidence.

Fourth, health and microfinance institutions should receive support in piloting and replicating insurance products to help low income households manage the risks associated with the crisis.

And, finally, support should be provided to the development of cross-sector practitioner fora to share experiences and develop operational partnerships to confront the AIDS crisis.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Scofield follows:]

PREPARED STATEMENT OF RUPERT SCOFIELD, EXECUTIVE DIRECTOR, FOUNDATION FOR INTERNATIONAL COMMUNITY ASSISTANCE

"CONFRONTING THE AIDS EPIDEMIC IN AFRICA THROUGH MICROFINANCE"

Ramulati Kibirige was the mother of two children. Sadly, her 22-year-old daughter recently died of AIDS, and she was left to care for her daughter's four children. When her sisters died, she also took in their children. Because she has a small business and is seen as fiscally responsible, the care and support of 15 children—most of whom are AIDS orphans—has fallen to her.

Ramulati runs a successful business with two employees, baking and selling pastries such as sambusa, mandazi and chapati. With her first FINCA loan of $35, she was finally able to buy raw materials in bulk, allowing her to take advantage of wholesale prices and to generate larger profits. With on-time payments and successive loans totaling $317, she has been able to increase her production. With the profits she earns, she is not only helping to meet the daily nutritional needs of her family, but to pay the children's school fees.

The success of her business and her participation in the FINCA program has given her more than an income, it has given her confidence: "I used to not be able to speak in front of people," she says, "because I was afraid. Now I have no fear." Despite the sadness and struggle that AIDS has brought into her life, Ramulati remains optimistic. "Because I am working, we are happy in our home," she says.

I. OVERVIEW

FINCA International is a global microfinance intermediary that provides over $60 million in loans annually to 175,000 clients, 94% women, through a world-wide network of over 10,000 village banks in the Americas, Africa, and Asia. FINCA's on-time loan repayment rate averages 96%.

FINCA's network in Africa has grown to serving over 68,000 clients through 2,640 Village Banks in the countries of Uganda, Malawi, Tanzania, South Africa and Zambia. By the year 2005, FINCA's strategic plan calls for expanding this program in Africa to over 5,600 village banks and 140,000 clients.

Due to the AIDS epidemic, FINCA and its clients face unique challenges in Africa. Among the hardships faced by our clients are the burdens of additional health care costs, burial costs, the costs to support orphan children of friends and relatives and of course the emotional pain of losing their loved ones from this dreaded disease.

In Uganda, over 80% of FINCA's clients are currently caring for and providing financial support to children orphaned by AIDS and AIDS victims. For FINCA as an institution, the AIDS epidemic poses many unique problems as well. The loan portfolio can suffer arrears when clients fall sick and die leaving unpaid loans. Under FINCA's system, these are the responsibility of the other members of the village bank. Many fine FINCA employees have also succumbed to this disease since we first went to Africa 10 years ago. Given this daunting operating environment FINCA has been faced with a choice to limit our risk and operations in Africa or meet the challenges of AIDS head on and adapt our programs in such a way to help both our clients and our institutions survive. We have chosen the latter course.

II. THE ROLE OF MICROFINANCE IN THE AIDS CRISIS

There is growing consensus that microfinance can be a powerful tool in a larger campaign to reverse the spread of AIDS and strengthen the ability of communities to cope with the impact of the disease. Specifically, microfinance can play a significant role at the various stages of the disease: prevention, detection, mitigation and in the aftermath of a death.

Over the last five years, microfinance has advanced dramatically across the African continent because over 80% of employment is generated through the informal sector. This means that most poor families in Africa generate their livelihoods in part through some form of self-employment activity. Since these families do not have access to formal financial services, they must turn to moneylenders who can charge as much as 10% interest daily.

For this reason, FINCA and other microfinance institutions have encountered a huge demand for micro-business loans averaging between $50 and $200. These families have found such services to be critical in preparing them to overcome poverty and all of its concomitant challenges, including AIDS.

FINCA's mission is to work with very poor people. In Africa, FINCA usually operates in communities that are severely affected by the AIDS crisis. By sapping vital economic and social resources, the AIDS crisis creates a downward spiral that affects the entire community and can lead families into complete destitution. FINCA's goal is to reverse the spiral by creating the necessary economic and social backbone to weather the negative impact of AIDS on the communities.

FINCA operates through a financially sustainable model. The institution can thus leng beepis to monies with commercial capital to multiply scarce resources. This permits FINCA to expand the scope of its services to meet the overwhelming challenge that AIDS poses to the economies of poor communities in Africa.

III. FINCA'S STRATEGY FOR RESPONDING TO THE AIDS CRISIS

FINCA is responding to the crisis according to three pillars: 1) Helping communities devastated by AIDS create an economic and social safety net through FINCA's core financial products; 2) Innovating new financial products to help households and institutions mitigate the economic risks of the AIDS crisis; and, 3) Disseminating health education and services through alliances with health organizations. The three pillars are outlined below.

1) Helping communities devastated by AIDS create an economic and social safety net through FINCA's core financial products

FINCA's Village Bank loans and savings products preserve and help individuals and families build the economic safety net of communities affected by AIDS. FINCA serves HIV-negative and HIV-positive clients. Informally, FINCA employees attest that a large number of their clients are likely to be HIV-positive. FINCA respects however the absolute anonymity of these clients. In 1995, FINCA received financing from USAID's Displaced Orphans Fund to support communities in Uganda where a high incidence of AIDS lefo many orphans in the care of relatives and friends. As previously noted, over 80% of FINCA's clients in Uganda are caretakers of AIDS orphans and victims of AIDS. As shown in Uganda, profitable FINCA-financed businesses allow micro-entrepreneurs to care for AIDS orphans and victims of AIDS while maintaining their businesses. Access to savings products also allows clients to build reserves to cope with the impact of the crisis. As a result, most of these clients become caretakers within their community.

Receto surveys indicate that the most problematic economic aspects of HIV/AIDS for poor working families in Africa are: medical expenses, the need to feed their

families despite high medical expenses, the need to finance funerals, and finally the need to take care of HIV/AIDS orphans and victims of AIDS.

Microfinance institutions can offer services that reduce the risks of depleting productive assets and savings and manage the losses in income due to HIV/AIDS related expenses.

Specifically, microfinance services can:

- Help to build up savings and productive capacity of the household before the disease deeply affects a household.
- Strengthen the informal safety net at the community level.
- Support the productive activities of healthy family members caring for the sick and orphans.
- Provide the economic support for death-related expenses (funerals) and to rebuild a sound economic basis for the household.
- Empower women by raising their economic status, improving nutrition, health, and education to prepare them to meet the challenges of poverty and the AIDS epidemic.

2) Innovating new financial products to help households and institutions mitigate the economic risks of the AIDS crisis

FINCA has been experimenting with new financial products such as insurance that help families cope with the risks of the AIDS crisis. These products include credit insurance and health insurance. FINCA also envisions the possibility of introducing funeral insurance and health emergency loans.

Credit and Life Insurance

FINCA Uganda offers credit and life insurance through a unique partnership with a formal sector insurer, AIG. The objectives of the life insurance program are twofold. From the client's perspective, the insurance pays the balance of a group member's loan in case of her death or disability for any reason, taking the burden off the other members of her Village Banking group. In the case of a client's accidental death, the insurance pays a specified amount to family members whom a client designates as beneficiaries. The credit insurance also reduces the incentive for groups to exclude people with health problems, including HIV/AIDS, since they may receive coverage.

Health Insurance

In collaboration with local hospitals and a US-based HMO, FINCA Uganda is currently developing a health care insurance program through which FINCA's clients have easy and affordable access to health care. A typical premium is $48 a year for a family of four to cover preventive, primary and limited acute care. Although the benefits do not include direct AIDS treatment, the scheme provides treatment for many AIDS-related illnesses. Triple viral therapy is not included, but the treatment of resultant diseases is an important step forward for covered individuals afflicted with HIV/AIDS in increasing life expectancy and improving quality of life. While it holds promise, this program is still in its experimental stage.

Future innovations could include:

- *Health loans* to meet temporary health expenses for the client or his/her relatives.
- *Trust funds* to protect the assets and redirect them to children and other relatives when a client dies.

FINCA's first efforts to bring health insurance to clients included a pilot project in Uganda. "The Health Care Program" started in mid-1999 through a reputable mission hospital, Nsambya Hospital in Kampala, and was extended to Kitovu Hospital in Masaka. The client, her husband, and two children are covered under the standard payment. A client may choose to cover additional children or family members for an additional fee.

For a Village Banking group to qualify for this plan, 60% of its members had to agree to participate. The pilot of this program involved 130 families. Since that time, word has spread, and there is a huge demand to extend the program. FINCA is enthusiastic about the current developments of establishing new partnerships that will bring health services to a larger population of our clients.

FINCA has always promoted client savings as a way of helping our clients cope with emergencies. The poorest families are often the most vulnerable to diseases, disaster, and accidents, since they often have no "safety net." These insurance programs provide an additional measure of economic stability to FINCA's clients as well as a layer of protection for their precious life savings. An article from the *Fi-*

nancial Times [1] last October praised FINCA's work in this arena suggesting that it could "revolutionize the lives of Africa's poorest."

3) Disseminating health education and services through alliances with health organizations

FINCA's village banking infrastructure provides a distribution channel for a variety financial and non-financial services. FINCA clients assemble weekly to process loan payments and collect savings. Their weekly village banking meetings provide an opportunity for education.

Recognizing the potential of its network of village banks to provide an infrastructure for health education, FINCA began in 1996 to partner with local organizations to offer education and health support services to its members. These organizations sent representatives to Village Banking group meetings to help educate FINCA clients in AIDS prevention methods, in caring for family members with the HIV virus, and in serving the needs of children orphaned by the disease.

With Village Banking groups in some 700 communities throughout Uganda, FINCA provides a wide network for education and information dissemination. The training and education that takes place in our Village Banking group meetings is merely the tip of the iceberg. Our clients take the lessons they have learned on preventing the spread of the disease, and on caring for those who are ill, back to their homes and their families. As a result, Ugandans are better informed about the disease. Moreover, FINCA's Village Banking model can encourage the internal coping mechanisms by providing a forum where the clients can rely on each other for care and support.

One cautionary note: clients greatly value their time and demand efficiency. In order to be effective, AIDS education programs must be succinct and prompt. When these programs have not respected these principles, clients lose interest quickly. Education programs must be voluntary. In order to speed access to information FINCA has experimented with sending its credit officers to HIV education training themselves so they can provide timely information and answer questions regarding HIV issues.

FINCA's Village Banking model thus offers the infrastructure to design innovative health services in partnership that can include:

- Partnerships with healthcare providers on information and preventive care
- Partnerships for legal advice on inheritance rights for relatives or for a client if her husband dies
- Loan products to finance daycare centers to care for sick relatives to allow the micro-entrepreneur to continue her business. (FINCA Uganda finances such day care centers in many communities.)

The members of the Village Bank represent a formidable force in the fight against AIDS. Through the Village Bank framework, they can be the premier actors in the distribution of vital health services, such as:

- Community-based pharmacies through partnerships with pharmaceutical companies. The idea is to utilize the purchasing power of the group to access affordable medicine.
- Tapping FINCA's large network of entrepreneurs as distribution points for health-related products and other medical supplies.

IV. Recommendations to the House International Relations Committee:

As the Committee considers legislation on responding to the AIDS crisis, FINCA would suggest laying out the architecture of a global AIDS initiative that comprises a comprehensive package. The package should include interventions that help communities prevent infection and care for victims and orphans of the disease. Since poverty is a root cause of the spread of the disease, raising the income status of poor women through microenterprise development should also be a key part of the package. If empowered, these women can stand as a powerful social force to fight the spread of the disease.

From the vantage point of a microfinance institution, we suggest that a comprehensive package include the following principles:

1. Health and microfinance institutions should be supported to develop operational partnerships for providing comprehensive support services to commu-

[1] "Micro-Finance: A village project based on a small weekly payment could revolutionize the lives of Africa's poorest" *The Financial Times* 10/11/00.

nities devastated by AIDS including preventive education, microenterprise development and health care.

2. In order to have a systemic impact commensurate with the scope of the AIDS crisis, health and microfinance institutions should use service delivery models that are scalable. When possible, they should be structured on a cost-recovery basis so that scarce program resources are perpetuated, multiplied and leveraged with private sector capital.
3. Microfinance institutions should strive to serve both HIV-negative and HIV-positive clients. They should avoid creating incentives to exclude HIV-positive clients while using credit insurance to mitigate risk. If known, the health status of clients should be maintained in strictest confidence.
4. Health and microfinance institutions should receive support in piloting and replicating insurance products to help low-income households manage the risks associated with the crisis.
5. Support should be provided to the development of cross-sector practitioner fora to share experiences and develop operational partnerships to confront the AIDS crisis.

Mr. SMITH. Mr. Scofield, thank you very much for your testimony and for your very specific recommendations to the Committee which will be looked at very carefully and we do thank you for that.

I would like to ask Mr. Dokmo if he would proceed.

STATEMENT OF CHARLES DOKMO, PRESIDENT AND CEO, OPPORTUNITY INTERNATIONAL

Mr. DOKMO. Thank you, Mr. Chairman, for inviting me here today. I represent Opportunity International, a pioneer and leader in microenterprise development. In the past 30 years, opportunity has provided one million jobs for some of the world's poorest people. I have looked into the eyes of women living with AIDS and agonized about their fate. I have also met women who have dramatically reduced their risk of AIDS by overcoming extreme poverty through microenterprise development programs. These women have hope. They give me hope as well.

Mr. Chairman, may I show a photo?

Please meet Kayania Crosie from Rakai, Uganda, the AIDS epicenter. She is raising seven girls, four are AIDS orphans. With their $300 microloan, she has started a tailoring business that supports them all. She is teaching all the girls to sew. They all have a safe, dignified way of earning a living.

Mr. Chairman, you have assessed the tragedy with empathy, solid facts, and proven interventions. You have crafted a masterful plan that prevents AIDS and mitigates its devastating consequences. I like that the plan focuses on prevention, counselling, and testing. I like that the plan builds on the heroic efforts of volunteers. I like that the plan fortifies health care delivery. I especially applaud your plan for recognizing that microenterprise development plays a critical role in the fight against AIDS. Microenterprise provides income for families affected by AIDS, provides women with the power to make economic and relationship choices, provides sustainable and scalable programs to reach millions of families.

Opportunity International's main strategy is group lending through what we call trust banks for women like Kayania who have no source of credit except from the loan sharks who charge exorbitant interest. Trust banks have up to 50 members, about the

size of this Committee. They meet every week to repay loans and to develop business, health, and social skills. Peer leadership and group accountability keep the loan repayment rate at 97.5 percent or better. These meetings are an excellent venue for AIDS counselling and testing.

The primary way microenterprise programs contribute to the fight against AIDS is providing income for families affected by the pandemic. In the hardest hit countries, we estimate that four out of every five trust bank members or clients are caring for orphans. Trust banks provide economic strength for people caring for loved ones suffering from AIDS and for the widows and orphans they leave behind.

The second way microenterprise combats AIDS is by providing women with the economic power to be in relationships with the men of their choosing. Barry Bloom, Dean of the Harvard School of Public Health said "Empowering women is critical to controlling the epidemic."

A trust bank member from Zambia recently told me "When your children are starving, you have to take whatever man comes along."

Through trust banks, women have the power to make intimate encounters a matter of choice, not survival.

I would like you to remember two other powerful benefits of microenterprise development.

Number one, programs are sustainable. Nearly every cent, every penny, you commit to microenterprise will be repaid and recycled into loans. It is not money spent and gone.

Number two, trust bank programs are quickly scalable. Last year, we launched our own African Microenterprise AIDS Initiative to increase the 2000 trust banks we currently support to 10,000 in 5 years. By 2005, we will be serving a quarter million families. If H.R. 2069 is passed, and other microenterprise groups like FINCA join us, together we will have the capacity to reach 20 million adults and children.

As Congressman Lantos stated earlier, we strongly agree with Secretary Powell's statement during his recent trip to Africa. This is more than a health issue. This is an economic issue. This is an issue of poverty. It is an issue of the destruction of a society.

This plague is wiping out a continent before our eyes. It is my personal conviction that we need to marshal our resources and lead the way for other countries to join us in a massive assault.

Mr. Chairman, may I show one more photo?

I would like you to meet Mrs. Kwa. I met her recently in Ghana. She has an Opportunity Trust Bank loan of $60 and I asked her where she would be now if not for her loan and she told me that her husband had died of AIDS many years ago and she said, "My children would not be in school and I probably would be dead."

Today, Mrs. Kwa has hope.

Mr. Chairman, this bill, I believe, will deliver hope to millions.

Thank you.

[The prepared statement of Mr. Dokmo follows:]

PREPARED STATEMENT OF CHARLES DOKMO, PRESIDENT AND CEO, OPPORTUNITY INTERNATIONAL

ABOUT OPPORTUNITY INTERNATIONAL

Opportunity International was founded in 1971 by a small group of American business leaders who sought a solution to poverty that tapped into the spirit of enterprise and created dignity without dependency. In 2000, Opportunity loaned $64 million, which created or strengthened more than 240,000 small enterprises in Africa, Asia, Latin America, and Eastern Europe. By 2001, after 30 years of serving the poor, Opportunity had provided 1 million jobs in some of the world's poorest neighborhoods. Now, Opportunity has set an ambitious goal to reach 1 million families *per year* by 2005, while achieving a "triple bottom line" of increasing outreach, maximizing financial self-sufficiency, and transforming lives.

Opportunity is concerned about more than just helping people become successful entrepreneurs. It has a dual mission: creating jobs and changing lives. It is committed to the transformation of the poor by facilitating holistic development that addresses the economic, social, political, and spiritual dimensions of their lives.

In Africa, Opportunity International currently serves 50,000 clients, of which 93 percent are women. Opportunity estimates that one in five clients in Africa may be HIV positive and will eventually die of AIDS-related illness. The impact on families, orphaned children, women supporting families, and adopted survivors will be immense. Opportunity International is committed to reducing the devastating effects of HIV/AIDS on disadvantaged families and is focusing on providing income opportunities for women.

In the past few years, Opportunity International has sought to engage and leverage our microfinance expertise in the fight against the AIDS pandemic. Two years ago, an international team explored how Opportunity International could best help stop the spread of HIV/AIDS through its microenterprise programs. Much of the team's work focused on adopting Opportunity's "Trust Bank" model to meet the needs of poor women and their communities.

BACKGROUND ON THE FIGHT AGAINST HIV/AIDS

In the early 1980s, as AIDS was just beginning to surface in the global consciousness, medical doctors and social scientists began an aggressive campaign to combat HIV. Their strategy of increasing preventative knowledge was widely viewed as the best weapon readily available in a limited arsenal. Twenty years later, social scientists report that this campaign has largely failed. Studies debate the actual figures, but most experts now agree that although HIV/AIDS awareness is fairly common among African citizens, that awareness has not generally been reflected in a reduction of incidence of HIV.[1]

If awareness has not reduced the rate of infection, the question that must be answered is this: what other factors, apart from ignorance about HIV, are contributing to the high rates of HIV in certain African countries? In answering this question, global health experts have shifted from the traditional behaviorist model and have sought to find solutions within socioeconomics. It is their contention (after years of observation) that poverty, along with certain gender norms, have created an atmosphere conducive to the spread of HIV.

MICROENTERPRISE DEVELOPMENT AS AN EFFECTIVE TOOL IN THE FIGHT AGAINST AIDS

Nowhere is the imperative to link the provision of economic empowerment with proven prevention strategies seen more clearly than with people affected by HIV/AIDS. Strengthening the economic capacity of individuals, families, and communities prevents the spread of HIV/AIDS and mitigates its damaging effects.[2]

As a premier microfinance network operating in sub-Saharan Africa, Opportunity International is in a unique position to address the problem of AIDS among the impoverished families of this region. Because most experts now agree that the lack of cultural and economic power is a key factor in the transmission of HIV, financial and nonfinancial resources must be made available to those who are helpless to defend themselves against HIV infection.

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[1] C. Rosenvard and T. Campbell, *A review of sexual behavior change studies from sub-Saharan Africa: What lessons can we learn for the future?* International Conference on AIDS, Lusaka, Zambia, July 7–12, 1996, p. 11.

[2] John Williamson, *Finding a Way Forward: Principles and Strategies to Reduce the Impacts of AIDS on Children and Families* (an evaluation report prepared for USAID) (Washington, D.C.: Displaced Children and Orphans Fund and War Victims Fund Contract, March 2000).

"Opportunity International's plan provides the missing link in the fight against AIDS, which is economic empowerment. Women tell us that because they are economically dependent on men, the degree to which they are able to express their own will is limited."

—Debrework Zewdie, HIV/AIDS Coordinator, World Bank

TRUST BANKS

Opportunity's main lending method is group lending through Trust Banks. Trust Banks are groups of 30 to 40 members, mostly women. Trust Bank members receive microloans so that they can improve their lives by opening small businesses such as market stalls, dressmaking shops, beauty salons, and chicken farms. Because of their poverty, they have no source of business credit—or any credit—except from loan sharks who charge exorbitant interest.

Members meet every week to repay loans and to develop the business, family living, and social skills they need to transform their lives. These weekly meetings are ideally structured to incorporate an HIV/AIDS peer education program. Meetings last for 1 to 1.5 hours and typically include a discussion or activity session. AIDS educators regularly facilitate discussions at weekly meetings. These discussions address gender-related risk factors and provide a forum where the women receive counsel for their real-life problems.

By design, Trust Banks are intended to empower those who need a boost so that they can provide for themselves. Participants gain cultural and economic power, which enhances their personal dignity. By providing a loan, the Trust Bank says, "We believe in you," and places a measure of responsibility upon the borrower's shoulders. As members continue to build community with others who have cross-guaranteed their loans, a support network forms. Peer leadership and peer support keep the loan repayment rate at around 100 percent.

INCOME FOR FAMILIES AFFECTED BY HIV/AIDS

The most important way Trust Banks and other microenterprise programs contribute to the fight against AIDS is by providing income-generation opportunities for families affected by HIV/AIDS. In countries such as Zimbabwe, Zambia, and Uganda, no family has escaped the impact of AIDS. Because of its incremental nature, AIDS is unlike any other disaster. AIDS diminishes family resources over several years. At the same time, the number of sick family members and orphaned relatives continues to increase. In the years ahead, the impact of HIV/AIDS on children, their families, and their communities will expand into dimensions difficult to imagine.

Next-of-kin traditionally care for orphans in Africa, but the burden of care is crushing to families already living in abject poverty. Research shows that in severely affected countries, as many as 75 percent of all households care for one or more orphans.[3] We estimate that four out of every five of our Trust Bank members are caring for at least one orphan. Many families that take in orphans cannot afford the additional expense, and the orphans are often the first to be denied basic necessities and schooling. "My foster mother wants to stop me from going to school. She wants me to work as a maid so I can earn money to buy food," says 16-year-old Beatrice from Kenya.[4]

The family is not a social sponge with an infinite capacity to absorb the costs of HIV/AIDS. Trust Banks provide an income for people who are caring for loved ones and neighbors suffering from AIDS and for the widows and orphans they leave behind. Trust Banks and other forms of group lending specifically target the following groups:

- *Unemployed women*—Trust Banks provide women with financial alternatives to selling or bartering their bodies. The peer support structure helps them make the transition to healthier lifestyles.
- *Young girls*—By increasing income, the family's needs are met so that young daughters do not have to be offered to men who pay household expenses in return for sex.
- *AIDS widows*—An income-generating activity secures economic status, and the Trust Bank meetings provide the necessary support structure to begin a new life. These outcomes are paralleled by near-total transformation of the widows' self-respect.

[3] "Orphans of the Virus," *Economist*, August 1999.
[4] *The Orphans of AIDS: Breaking the Vicious Circle*. London: Panos Institute, October 1997.

- *Children affected by HIV/AIDS*—Income from the microenterprises helps women care for their orphan kin in addition to their own children. A large network of Trust Banks in Africa may be the best way to address the problem of how to support AIDS orphans.

THE POWER TO SAY NO

The second way microenterprise combats AIDS is by providing women with the economic *power* to be in relationships with the men of their choosing. Barry Bloom, dean of the Harvard School of Public Health, has said, "Empowering women is critical to controlling the epidemic."

Disadvantaged African women require both economic empowerment and HIV/AIDS education to reduce significantly their susceptibility to HIV. Their lack of resources and understanding consigns them to high-risk sexual behavior. A Trust Bank member from Zambia said, "When your children are starving, you have to take whatever man comes along. But we're not starving now. I have a choice." Because she now has a livelihood, she has the freedom to reject sexual encounters. Through Trust Banks, the power of one individual is multiplied by the power of the 30 other members. Through Trust Banks, women earn the *power* to say no or negotiate safe sex.

When women have the knowledge to make informed choices, their empowerment is complete. By adding HIV/AIDS education and services, Trust Banks become an effective combined intervention program targeting poor women in Africa. The business meetings where required weekly loan repayments are made provide a forum for the delivery of information on AIDS prevention. Meeting often with peers who hold each other accountable can strengthen women's resolve to adopt risk-reduction behaviors.

SUSTAINABILITY AND SCALABILITY

The third way microenterprise development is significant in the fight against AIDS is that it is sustainable and scalable. Every dollar committed to microenterprise will be multiplied several times over as loans are repaid and recycled into more loans. It is not money spent and gone. Sustainability relates not only to the program, but also to the lasting, real-life solutions that microenterprise brings to individual loan clients.

The mothers and children of Africa represent a suffering continent's best hope for the future. Incorporating a sustainable income-generation and empowerment program as part of a strategic response to HIV/AIDS will ensure that thousands of families are protected from some of the worst consequences of the epidemic. Families participating in the group programs typically double their income within three years. The increased income transforms the family. This positive progression begins with improved nutrition leading to greater resistance to disease and higher energy for work and learning. Incremental investments are soon made in the children's education, followed by basic home improvements. And finally, these outcomes are paralleled by a near-total transformation of the client's self-respect.

Microenterprise development also introduces scalability into the fight against AIDS. If we are to be relevant to the problems of HIV/AIDS, our effort must be massive. Demographics are shifting as a result of HIV/AIDS. Gaps are widening in the population pyramid, coinciding with multiple deaths among the age groups most affected: women 20–35 years old and men 25–45 years old. These gaps will create a shortage of both wage earners and caregivers. The social and economic effects of HIV/AIDS will increase the poverty and vulnerability of families and communities.

Last year Opportunity International launched the African Microenterprise AIDS Initiative. Year-one funding for this ambitious effort was made possible through $2 million in grants provided by the Samueli Foundation, International Foundation, Bradley Turner Foundation, SAJE Foundation, and many individual supporters. The initiative's innovative and sustainable model will address the myriad complexities of the AIDS problem in Africa and provide a blueprint for other groups fighting to eliminate the disease from the continent.

The African Microenterprise AIDS Initiative will increase the 2,000 Trust Banks and solidarity groups in Africa that Opportunity International currently supports to 10,000 in five years. By 2005 we plan to be serving 250,000 families, or 1.5 million adults and children. We can do this if we are able to secure $30 million in additional funding. If another $200 million were available and other microcredit groups were to join with us, together we would be able to reach an additional 20 million adults and children over the next decade.

CONCLUDING REMARKS

Dr. Jonathan Mann, the ex-UNAIDS chief who died on Swissair Flight 111, was the first to link the spread of HIV/AIDS with poverty and gender inequality. In arguing that widespread discrimination against women limited their freedom to leave men who refused to practice safe sex, he wrote:

> Vulnerability is the converse of empowerment. . . . A person who is genuinely able to make free and informed decisions is least vulnerable (empowered); the person who is ill informed, or whose inability to make informed decisions freely and carry them out, is most vulnerable. Empowerment occurs when people realize that some important aspect of their *lives can be different*. A second element in empowerment is a sense of self-efficacy, the idea that *change is possible*.[5]

Opportunity International and the African Microenterprise AIDS Initiative will bring dignity to disadvantaged women and families. It will help them see that their lives can be different and that change is possible. By joining together in Trust Banks, women in thousands of communities will transform desperate societies, illustrating the African proverb, "the power of many hands and minds is unequalled."

Mr. SMITH. Mr. Dokmo, thank you very much.

I would like to ask our final witness, Dr. Zeitz, if he would proceed.

STATEMENT OF DR. PAUL ZEITZ, CO-DIRECTOR, GLOBAL AIDS ALLIANCE

Dr. ZEITZ. Thank you, Mr. Chairman, and Members of the Committee for this opportunity to present my recommendations to you on the United States' role in stopping the global AIDS pandemic. This hearing is of vital importance and I commend you and the entire Committee for your leadership and serious attention to the issue.

We would also like to commend Chairman Hyde for his recently introduced legislation which has accelerated the dialogue regarding what an appropriate U.S. response should be.

For 6 years from 1994 to the year 2000, I had the opportunity to live and work in the Southern African nation of Zambia as a policy and technical advisor for the government of Zambia, USAID, and UNAIDS. I lived for many years in the center of the AIDS holocaust and this is a holocaust.

Today, I am here representing the Global AIDS Alliance, of which I am the co-director. The Global AIDS Alliance is a newly formed, broad-based coalition of world citizens joining together in the fight against the global pandemic. We have a major focus on mobilizing African civil society and I bring you greetings today from our co-director, Chintinka Ancoma, who is in our Malawi office working on that initiative.

My testimony today brings to you perspectives from nongovernmental civil society, based on our real world frontline experience.

The reality of the AIDS crisis hit home to my family and I several years ago when more and more of our Zambian friends started dying, when my Zambian work colleagues started dying more frequently and were never replaced, when the number of orphans around us were increasing exponentially, when my wife and I were asked by friends to use our family van to transport a 3-month-old deceased child by the name of David from the morgue to his funeral in Zambia, and after I personally had refused to go to any

[5] Jonathan Mann and Daniel Tarantola, *AIDS in the World II: Global Dimensions, Social Roots, and Responses* (New York: Oxford University Press, 1996), p. 441.

more funerals as I had heard enough of the howling cries of grief, and on and on and on the tragedy rages.

I was shocked and devastated when I learned that the AIDS death rates that I was observing in Zambia will not peak for another 5 years, until 2005, and then they will stay high for a subsequent 10 to 15 years, effectively wiping away a full generation of people just like you and me. Women and young people are disproportionately affected. Those that are dying are women and men with families, people with dreams just like you and I. These are people who deserve a chance at life, liberty, and the pursuit of their God-given potential.

It is outrageous from both a practical and a moral standpoint that 99 percent of Africans are not able to obtain lifesaving antiretroviral medications because of a simple lack of resources. I respectfully disagree with the earlier comments of Administrator Natsios. There is existing infrastructure in Africa. There are roads in Africa. And Africans can tell time. And, most importantly, Africans want to live as much as anyone else.

How many more Africans have to die? Just imagine what our response would be if millions of Americans or millions of Europeans were destined to die because they did not have the resources to buy these readily available drugs.

When one considers that 17 million Africans have already died and that another 2.5 million are dying this year and several million will die next year and several more the year after, one can only conclude that the international and the U.S. response is failing.

If we are serious and truthful about our intention to stop global AIDS, then we should ask ourselves what should we do now.

Bold, bipartisan U.S. congressional action and investment in reversing the tide against global AIDS is urgently needed. The incremental response of pilot programs, small-scale investments that characterized our response of the 1990's, has shown us that we have the prevention, care, and treatment tools and technologies and tactics to respond to the epidemic, but our response paradigm has failed.

Mr. Chairman and Members of this Committee, all of this devastation is completely preventable. There is a global consensus that we have the proven technologies and tactics to reverse this crisis. What we are still lacking is a sufficient political will. A new and expanded comprehensive response to the AIDS pandemic—a new paradigm—can and must be implemented as a matter of urgency.

It is our view that the global AIDS crisis requires the specialized skills of different U.S. agencies, including USAID, the Department of State, CDC, HHS, and the Department of Defense. Bipartisan congressional action is required to ensure that new and supplementary resources are appropriated for USAID and other agencies to support the rapid scale up of programs in all appropriate countries. Only three of 48 countries in Africa are receiving scale up support from USAID and there is clearly a lot more absorptive capacity.

At least $500 million per year is needed for USAID to respond effectively. The Administration and Congress cannot expect that a reallocation of existing resources from one account to another will

achieve the desired results. A real and genuine supplementary appropriation is required.

We are greatly encouraged by the recent interest of the U.N., the G–7, the IMF, and the World Bank in establishing a Global AIDS and Health Fund to combat AIDS, TB and malaria with up to $10 billion per year in grants. The Global AIDS and Health Fund should be negotiated with the full participation of nongovernmental civil society.

To date, civil society has had a limited and marginalized role in the discussion regarding the creation of the fund. This lack of transparency gives us cause for great concern. Bipartisan action is needed to ensure that a transparent civil society consultative process is convened as a matter of urgency to ensure that civil society leads rather than follows the design and implementation of this mechanism.

Under an international burden sharing arrangement, the United States should commit to provide its fair share of the cost of the $10 billion per year Global AIDS and Health Fund by appropriating $3 billion this year as that would be proportionate to the 30 percent U.S. share of the global economy.

President Bush's recent announcement of a $200 million contribution to this fund is a small start, but remains woefully inadequate as it represents only 6 percent of an appropriate U.S. contribution to this mechanism.

Mr. Chairman, the World Health Organization estimates that the global standard of antiretroviral medications, commonly know as the triple cocktail treatment, indicates that about 5 million of the 27 million infected Africans should currently be taking these life-extending drugs. Antiretroviral medications reduce the amount of HIV in the infected person. This effect dramatically reduces sexual transmission and transmission from other to child while they significantly extend the person's healthy life.

By offering antiretroviral agents to HIV-infected people, prevention is also more likely to succeed. Access to treatment will greatly accelerate the destygmatization of AIDS as a death sentence, as HIV infection will rapidly be transformed into a manageable chronic disease.

Another compelling rationale for rapidly expanding access to antiretroviral agents is orphan prevention. By treating parents with these drugs, we can effectively keep mothers and fathers alive. As the father of five energetic sons, I know that my healthy presence is needed and occasionally appreciated each and every day.

Bipartisan congressional action is required to provide significant funding for the bulk procurement and distribution of antiretroviral agents at best world prices. Generically manufactured drugs must be included in this system so that these drugs can be co-formulated to optimize safe and effective use in resource poor settings. This is not possible with only patented products.

In addition, we believe that it is essential to create an international drug and commodities anticorruption program that expands ongoing efforts to stop corruption in the drug and commodities sector.

Mr. Chairman, many impoverished African nations pay more in debt servicing obligations each year than they pay on health, education, and HIV/AIDS programs combined. In fact, African countries' annual debt serving payments are $13 billion or $37 million a day from Africa to the IMF, the World Bank, the U.S. and other rich countries. This directly harms the ability of these countries to respond to AIDS.

Of the 23 countries that have received debt relief under the HIPPIC initiative so far, 15 still have annual debt servicing payments higher than what the country is currently able to spend on basic health care. Immediate debt cancellation by the IMF and the World Bank using their own internal resources to countries enrolled in the HIPPIC program could provide over a half a billion dollars per year for the HIV/AIDS fight without costing the American taxpayer anything and without negatively affecting the lending ability of these institutions.

Bipartisan congressional action is urgently needed to ensure that a new deal on debt to combat AIDS is approved by the G–7 leaders in Genoa, Italy in July. Immediate enactment of H.R. 1567, the Debt Cancellation for HIV/AIDS Response Act, introduced by Congresswoman Lee, would be a powerful statement of congressional action.

Mr. Chairman, Arnold Toynbee, a famous American historian, stated that "The 20th century will be chiefly remembered in future centuries not as an age of political conflict or technical inventions, but as an age in which human society dared to think of the welfare of the whole human race as a practical objective."

As we undoubtedly have the technologies, the tactics and the resources to stop global AIDS now, I ask the Members of this Committee to consider the question can we miss this opportunity and responsibility to ensure that our era will be recalled as a time when human society with a strong American and real American partnership join together to successfully stop global AIDS.

Thank you.

[The prepared statement of Dr. Zeitz follows:]

PREPARED STATEMENT OF DR. PAUL ZEITZ, CO-DIRECTOR, GLOBAL AIDS ALLIANCE

Thank you Chairman Hyde and Members of the Committee for this opportunity to present my recommendations on the United States role in stopping the global HIV/AIDS pandemic to you. This hearing is of vital importance and I commend you and the entire Committee for your leadership and serious attention to this issue. I will be presenting a brief summary of my views and I am submitting a full written statement for the Committee's consideration.

I am medical doctor with a specialization in international public health and epidemiology. I have focused my professional career over the past 12 years on striving to find real ways to assist people living in sub-Saharan Africa and in other impoverished countries to achieve a productive and healthy life. For six years, from 1994 until the year 2000, I had the opportunity to live and work in the southern African nation of Zambia as a policy and technical advisor for the Government of Zambia, USAID, and then I cofounded and served as the regional coordinator for UNAIDS Debt for AIDS Activity. I lived for many years in the center of the AIDS holocaust.

The reality of the AIDS crisis hit home to my family and I several years ago when more and more of our Zambian friends started dying, when my Zambian work colleagues started dying more frequently—and were never replaced, when the numbers of orphans around us was increasing exponentially, when my wife and I were asked by friends to use our family van to transport a 3 month dead child by the name of David to his funeral in Zambia, and after I had refused to go to any more funerals

as I had heard enough of the howling cries of grief, and on and on and on the tragedy rages.

I was shocked and devastated as I learned that the AIDS death rates that I was observing and experiencing in the late 1990s was just the beginning of what Zambia and much of sub-Saharan Africa, Asia, and parts of Eastern Europe will have to face. The AIDS death rates in Zambia and other areas won't peak until 2005 or later and then they are projected to stay high for a subsequent ten to 15 years—wiping away a full generation of people—just like you and I. Those that are dying are women and men with families, people with dreams—just like you and I—and young people throughout Africa are becoming infected at an alarming rate—these are people who deserve a chance at life, liberty and the full realization of their God-given potential.

It is outrageous from both a practical and a moral standpoint that more than 99% of Africans are not able to obtain practical life-saving antiretroviral medications, because of a simple lack of resources. Millions have needlessly died and millions more will die unless this Congress and the international community comes together with all deliberate speed to ensure access to affordable lifesaving drugs. How many more Africans have to die? Just imagine what our response would be if millions of Americans or millions of Europeans were destined to die because they didn't have the resources to buy these readily available drugs?

When one considers that 17 million Africans have already died and that another 2.5 millions are dying this year, and another several million will die next year, and several more the year after, and on and on. . . . One can only conclude that the international and the US response is failing. The first question that must be considered, is why are we failing as a global community to confront this crisis? We then must ask ourselves, "Why do we keep repeating the same policy and institutional responses and wondering why the results are so inadequate? And finally, if we are serious and truthful about our intention to stop global aids, then we should ask ourselves, "What should we do now?"

Bold, bipartisan US Congressional action and investment could play a critical role in reversing the tide against the global HIV/AIDS pandemic. While the incremental response of the 1990s has shown us that we have the tools and technologies to respond to the pandemic, our response paradigm has failed. The incremental response of the past is characterized by small inadequate investments in small-scale pilot programs that reach only a small proportion of the target population. It is the incremental response of the past that is leading to the 6,000 AIDS deaths and 16,000 new HIV infections that will occur around the World today. It is the incremental response of the past that is leading to the death of over 2.5 million Africans this year from AIDS. It is the incremental response of the past has led to the 13 million orphans roaming hopelessly throughout Africa, with a projected 40 million orphans by the year 2010.

Mr. Chairman and Members of this Committee, all this suffering is completely preventable. We have the proven technologies and tactics to reverse this crisis; what's still lacking is sufficient political will. A new expanded and comprehensive response to the HIV/AIDS pandemic—a new paradigm—can and must be implemented and sustained as a matter of urgency.

Today, I am here representing the Global AIDS Alliance (GAA) , of which I am the Co-Director. The Global AIDS Alliance is a broad-based coalition of the world's citizens joining together in the fight against the global HIV/AIDS pandemic. We are bringing together for the first-time a constellation of people living with AIDS and HIV/AIDS service organizations, the debt cancellation movement, treatment access campaigners, faith-based organizations, Africa and other ethnic and cultural advocacy groups, African-American leaders, human rights groups, student groups, and professional associations. My testimony today brings to you perspectives from civil society based on our real world front-line experience, so that we can work together to design and implement practical solutions to solve the global AIDS pandemic.

Our partners include Act Up; Africa AIDS Initiative; African Services Committee; AFRICARE; American Jewish World Service; American Public Health Association; Black Church Communal Network; Cameroon Baptist Convention Health Board; Church World Service; Constituency for Africa; Development Indian Ocean Network (DION); Drop-the-Debt Campaign; Essential Action; Ghana HIV/AIDS Network; Global AIDS Action Network; Health Gap Coalition; Institute for Policy Studies; International Health Medical Exchange, Jubilee USA Network; Jubilee 2000 Plus at New Economics Foundation; Malawi Network of People Living with HIV/AIDS; Malawi Network of AIDS Organizations; MIT United Trauma Relief; NAACP; Pan African Charismatic Evangelical Congress (PACEC); RESULTS; Student Global AIDS Campaign; United Methodist Church, General Board of Church and Society; and the Washington Office on Africa.

US LEADERSHIP IS REQUIRED TO STOP GLOBAL AIDS

Since the beginning of the global HIV/AIDS pandemic—20 years ago—the United States has been instrumental in demonstrating successful ways for combating the virus. Our efforts here in the United States have shown that when we invest sufficiently in available technologies and a grassroots community outreach, we can have a profound effect on reducing HIV transmission and treating infected people. Our support overseas has shown on a small-scale that cost-effective interventions can be applied in resource-poor settings and with positive results. Yet, we have not had the desired effect on reducing HIV transmission around the World because we have not invested sufficiently to do so. At this critical juncture in history, the United States has an unprecedented opportunity and responsibility to support and lead a more ambitious global effort to genuinely reverse the tide against AIDS.

United States leadership in the global effort to combat AIDS will also result in tangible benefits to the American people:

- US leadership will lead to faster and greater people-level impact in decreasing HIV transmission and reducing the impact of HIV/AIDS, thus reducing the risks of the global pandemic, including the spread of drug resistant strains of HIV/AIDS and TB, to the American public;
- US leadership in combating AIDS will protect US national security interests by reducing the need for US intervention in HIV/AIDS devastated countries in Africa, Asia, and Europe;
- US leadership in combating AIDS strengthen the US economy by strengthening the attractiveness of new markets.

ACTION ENVIRONMENT IN AFRICA

Over the past two years African political and civil leaders the World has witnessed an unprecedented shift in political will to battle the AIDS pandemic. Countries have developed National Strategic Plans that are being rolled out to the district and community levels, HIV/AIDS business coalitions are forming, churches and other faith-based groups are scaling-up their response. As the fragile democracies in Africa grapple with the vast challenge of combating AIDS, it is a tremendous opportunity for stronger democracies to lend a supportive hand. African families—and especially the youth—are willing and able to take on the responsibility to care for themselves, if they are given the information and tools to lead a safer, healthier life. On an individual level in Africa, we have an opportunity to help people understand that democracy doesn't result in suffering and death, but rather it can lead to improvements in the quality of life.

THE RESOURCE GAP

To implement an expanded and comprehensive HIV/AIDS response in sub-Saharan Africa, a recent report by the Global AIDS Alliance estimates that up to $15 billion in external grant resources are needed on annual basis from 2002–2007. The UN, the World Bank, experts at Harvard University have also estimated that an appropriate and adequate response to the global AIDS crisis will cost billions, not millions. The GAA estimate builds on data provided by earlier UN and World Bank reports, but projects achievable levels of population coverage and it includes cost estimates for infrastructure development, capacity building, and impact mitigation—which have not been previously addressed. Additional resources can be immediately used to finance the delivery of known interventions through the existing infrastructure, while at the same time strengthening and expanding new infrastructure over time.

The United States of America provides less than one-tenth of one percent of our GNP to overseas development assistance. This translates into US per capita support for overseas development assistance to be the smallest of all of the rich countries. America—the richest country in the history of the World, simply cannot be called the most generous nation on Earth. Some would even say we are, in fact, the stingiest. The paucity of US foreign assistance persists in spite of widespread support among the American people for greatly increased assistance to impoverished countries, as documented in several recent surveys. On top of this dreadful and embarrassing US policy towards the rest of the World, overseas development assistance from all sources to sub-Saharan Africa declined by 40% during the 1990s.

Although the HIV/AIDS crisis has led some donor countries to increase their foreign assistance allocations over the past several months, there is little sign that the level of funding needed to mount an effective response to the epidemic will materialize. After two years of intensive efforts by the UN and many others, it is esti-

mated that only between five hundred million and one billion US dollars of external grant resources will be spent annually over the next several years to combat the HIV/AIDS crisis in sub-Sahara Africa. That is far below what most experts believe necessary.

As a result of their poor economies, an overwhelming debt burden, inappropriate and externally imposed loan conditionalities, and minimal international investment, few impoverished countries in Africa or in other parts of the World can mount an effective national response to HIV/AIDS, nor can their citizens pay for treatment once infected. As of 1998, annual spending on HIV/AIDS in selected countries in Africa, from all sources, averaged less than $1/capita. This level of investment does not cover even the relatively modest amounts needed for basic HIV/AIDS prevention education and outreach, let alone cover the more significant investments needed for care and treatment of those already infected.

USING RESOURCES EFFECTIVELY

US Government Bilateral Response: The Critical Role of USAID

Historically, USAID has been the predominant United States Government agency implementing sustainable development programs overseas. However, in part because of the advent of globalization, an increasing number of US government agencies are now being drawn into global affairs. It is our view that the global AIDS crisis requires the specialized skills of different Agencies, and that supplementary appropriations should continue to be allocated to US agencies, such as USAID, Department of State, CDC, HHS, Department of Labor, and the Department of Defense. An accelerated and ramped-up involvement US bilateral agencies will be critical in the coming years. We also believe that the actions and investments of our bilateral programs should be complemented with a robust US investment in the UN-proposed AIDS and Health Trust Fund.

USAID, as the lead US government agency implementing HIV/AIDS programs, plays a critical role in advancing the development and delivery of cost-effective HIV/AIDS prevention strategies and on a more limited scale, USAID has supported a response to the orphans and vulnerable and children's crisis. These efforts have contributed significantly to the successful reduction of HIV transmission in countries like Thailand, Senegal, and Uganda. However, the fact remains that the epidemic is raging onward in many of the most impoverished countries around the World. With current level of funding, USAID is only able to provide full support for rapid scale-up in 3 of 48 sub-Saharan African countries. Bipartisan US Congressional action is required to ensure that the following policy priorities are implemented:

- New and *supplementary* resources are needed for USAID and other US Government programs to support rapid scale-up programs in all appropriate countries. At least $500 million dollars per year is needed for USAID to respond to the global AIDS pandemic. The Administration and Congress cannot expect that a reallocation of existing resources from one account to another will achieve the desired results. A real and genuine *supplementary* appropriation is required;
- USAID needs to expand its technical leadership to the full range of prevention, care, and treatment interventions. The rhetoric of prevention only has not worked and will not work in the future. USAID should provide support the *balanced implementation* of prevention, care, full treatment—including the use of antiretroviral drugs, the orphans response, infrastructure development, and capacity building;
- USAID and other agencies should redesign their strategic role to ensure that our US bilateral program is complementary to the newly UN-proposed Global AIDS and Health Fund (described below) to ensure that large-scale programs are successful;
- USAID financial management and bureaucratic procedures must be modernized and streamlined to ensure that US government resources are used to achieve the maximal impact in affected countries;
- USAID technical cadres must be dramatically strengthened to ensure that technically sound decision-making guides program development and implementation;
- USAID contracted agencies should be required to spend a larger majority of foreign assistance resources directly on programs that reach people, rather than on US-based offices and overhead charges;
- Congressionally designated resources for the orphaned and vulnerable children's response should be used for such purposes and reported on separately,

as has been historically done with the Displaced Children's and Orphans Fund;

It should also be noted that US government programs are not active in all countries because of US foreign policy considerations, therefore multilateral programs are essential to combat the global HIV/AIDS crisis.

UN-PROPOSED GLOBAL AIDS AND HEALTH FUND

We are greatly encouraged by the recent interest of the UN, the G7 governments, the IMF and the World Bank in establishing a Global AIDS and Health Fund to combat HIV/AIDS, TB, and malaria with up to $10 billion dollars per year in *grants*. These developments create an historic opportunity for many interested stakeholders to join forces to achieve our common objective of eradicating HIV/AIDS and other infectious disease crises. For a Global AIDS and Health Fund to be successful, questions of its governance and structure should be addressed openly and with the full participation of civil society stakeholders. Bipartisan US Congressional action is urgently required to ensure that the Global AIDS and Health Fund is consistent with the following principles that were endorsed by over 65 civil society organizations from around the World:

- The Global AIDS and Health Fund should ensure *full* participation by civil society—including youth, people living with HIV/AIDS, particularly women—in all aspects of the governance, design, and implementation of grants;
- For-profit interests who are potential large beneficiaries of the Global AIDS and Health Fund should not participate in its governance because of a conflict of interest;
- The Global AIDS and Health Fund should provide grants to civil, community-based, and non-governmental organizations, including faith-based organizations, to achieve the balanced implementation of HIV/AIDS prevention, care and support, treatment, response to orphans and vulnerable children, infrastructure development, and/or capacity building based on *country-driven* priorities;
- The Global AIDS and Health Fund should ensure that there is *full accountability* for resources, transparency, and effectiveness in the administration of the Fund;
- The Global AIDS and Health Fund should be completely *results-oriented*, with balanced set of streamlined processes for measuring success;
- The Global AIDS and Health Fund should ensure that funds are transferred through decentralized, *streamlined, and efficient mechanisms*, with a minimal bureaucratic burden;
- HIV/AIDS related medicines purchased with these funds should be obtained using a bulk procurement mechanism that is based on open competition, including bids for generically manufactured drugs, in order to expand access to high quality drugs at *best world prices*;
- Funding decisions should be made *independently* of whether governments have met structural adjustment conditionalities imposed on government by the World Bank and the International Monetary Fund;
- The Global AIDS and Health Fund should first be focused on the HIV/AIDS crisis, and related epidemics such as TB in *sub-Saharan Africa* and then expanded to other regions;

For these principles to be fully adhered to, we believe that the Global AIDS and Health Fund, while working in partnership with the international multilateral agencies, should maintain an *independent governance structure* and should establish innovative implementation mechanisms outside of routine operations of the multilateral institutions such as the UN, the World Bank, or the bilateral US government agencies.

The Global AIDS and Health Fund should be negotiated with the full participation of civil society. To date, civil society has had a limited and marginal role in discussions regarding the creation of the UN-proposed Global AIDS and Health Fund. This lack of transparency and wider participation of civil society in the design of these mechanisms gives us cause for great concern.

Bipartisan US Congressional action is urgently needed to ensure that the UN, G7, World Bank and IMF establish a *transparent consultative process*, as soon as possible, so that the design, governance, and institutional guardianship of the Global AIDS and Health Fund can be negotiated with *the full participation of civil society*. Bipartisan US Congressional action is needed to ensure that:

- An international civil society forum is convened as a matter of urgency to ensure that civil society leads, rather than follows the design and implementation of this mechanism. African civil society—which is leading the call for action, should be given a primary leadership role is designing this mechanism;
- Under an international burden-sharing arrangement, the United States should commit to providing its fair share of the cost of the $10 billion per year Global AIDS and Health Fund by appropriating $3 billion this year which would be proportionate to the 30% US share of the global economy. President Bush's recent announcement of a $200 million contribution to this Fund is a small start, but remains woefully inadequate, as it represents only 6% of an adequate US contribution to this mechanism;
- The United States should support efforts to accelerate negotiations with civil society, philanthropists, foundations, corporations, and governments to commit grant resources to meet the $15 billion per year requirements for full costs of combating the AIDS crisis in Africa.

EXPANDING ACCESS TO LIFE-EXTENDING ANTIRETROVIRAL MEDICINES

The World Health Organization global standard for the use of antiretroviral medications, known as the "triple cocktail treatment," indicates that approximately 5 million of the 27 million HIV-infected Africans should currently be taking these life-extending antiretroviral drugs. The benefits of these drugs include:

- Antiretroviral medications reduce the amount of HIV that an infected person has in their body. This benefit dramatically reduces HIV transmission through sexual transmission and from mother-to-child, while simultaneously extending the life of economically-productive parents;
- By offering antiretroviral agents to HIV-infected people in resource poor settings, prevention interventions are more likely to succeed. People will have a strong incentive to seeking voluntary counseling and testing (VCT);
- Access to treatment will greatly accelerate the destigmatization of AIDS as a death sentence, as HIV-infection will be rapidly be transformed into a manageable chronic disease;

Another compelling rationales for rapidly expanding access to antiretroviral agents is to implement *primary orphans prevention*. By treating parents with these drugs, we can effectively keep mothers and fathers alive. As the father of five energetic sons, I know that my healthy presence is needed, and occasionally appreciated, each and every day! Instead of helping families and communities cope with the 40 million orphans in the future, instead of focussing on succession planning, instead of rebuilding devastated societies from 2010–2020 . . . we should be investing now to keep parents and young people alive.

Despite the known and scientifically proven benefits of antiretroviral agents, only an estimated 5,000 Africans, or 1% of the total number of treatable Africans, currently have access to life-extending antiretroviral medications. International experts from around the World have testified that *existing infrastructure* through private sector clinics, employer-based programs, faith-based organizations, and other settings can be used to effectively and safely deliver antiretroviral agents. We also know that the production of high quality and effective generically-manufactured drugs puts a downward pressure on costs and allows for the coformulation of multiple drugs in ways that optimize their use in resource poor settings. Both patented and generically manufactured drugs must be utilized to increase access at the lowest possible cost, in ways that are consistent with international trade agreements.

The bottom line is that millions of lives around the World literally hang in the balance. Bold and urgent bipartisan US Congressional action and the full support of the Bush Administration, working in collaboration with other nations, can save these lives by optimizing public-private partnership efforts to expand access to essential medicines. Bipartisan US Congressional action is required to ensure that the following policy priorities are implemented:

- Provide bipartisan political support and funding for bulk procurement and distribution systems that rapidly expand access to life-extending antiretroviral medications;
- Ensure access to lowest cost drugs to treat AIDS and associated opportunistic infections, including support for the expansion of generically manufactured drugs so that antiretroviral agents can be coformulated to optimize safe and effective use in resource poor settings;

- Create an International Drugs and Commodities Anti-Corruption program, to effectively contribute to already promising and ongoing efforts to stop corruption in the drug and commodities sector.

DEBT CANCELLATION BY THE IMF AND THE WORLD BANK TO COMBAT HIV/AIDS IN AFRICA

Many impoverished African governments pay more in debt servicing obligations each year that pay on health, education, and HIV/AIDS programs combined. In fact, African countries are paying $13 billion a year, or $37 million a day in debt servicing obligations to the IMF, the World Bank, the United States, and the rich countries which directly harms the ability of these countries to respond to AIDS. In medical school, I was taught that as a physician my first obligation is to do no harm. By implementing deeper debt cancellation now, impoverished countries will be able to keep their own resources and we will start getting cash flowing in the right direction.

Creditor countries have finally accepted that a debt crisis exists in the poorest countries, and have taken steps to reduce the debts in 18 countries in Africa and I want to thank Members of Congress for the critical support that they have provided in support of debt relief. However, the benefits of the current creditor's plan are limited—these countries get just a one fourth cut in their annual debt service payments. Of the 23 countries that have received debt relief so far, in 15 the annual debt servicing payments will still be higher than what the country is currently able to spend on basic health care. In the case of Zambia, one of the poorest nations on the globe, payments will actually rise, despite debt reduction, and will remain at about a quarter of its national budget. In total, debt service costs for the poorest nations will reach $2 billion a year through 2005, in spite of the Heavily Indebted Poor Country Initiative (HIPC) debt relief program, if no further action is taken.

In the context of the HIV/AIDS emergency throughout Sub-Saharan Africa, the poorest region of the world, the case for more debt cancellation to help fund an expanded and comprehensive response to the HIV/AIDS crisis is clear. Immediate multilateral debt cancellation to countries enrolled in the HIPC program could provide over half a billion per year for the HIV/AIDS fight, without costing the American taxpayer anything, and without negatively affecting the credit rating of these institutions. World Bank and IMF debt cancellation in these HIPC countries would match what the US and most of the G7 countries have agreed to do. It is time for these institutions to cancel their fair share of the outstanding debt.

Deeper debt cancellation, with 100% cancellation by the International Monetary Fund and the World Bank, would be the clearest immediate signal of the international community's willingness to defeat HIV/AIDS in Africa by freeing up the required funds. This step would show that creditors recognize the HIV/AIDS emergency requires current debt "sustainability" to be redefined in order to release new and immediate resources. Already, some of the funds released by debt cancellation are being used to fight HIV/AIDS—for example in proven programs in Uganda, Tanzania and Cameroon. We need to build upon these successes. Nigeria has a democratically elected government that wants to win the war against HIV/AIDS—but can only do so if the international community can support the effort. Furthermore, Nigeria is poised precariously for an exponential growth of this killer disease if urgent action is not taken to stem the spread of HIV/AIDS.

Debt cancellation should not be made contingent on failed and harmful World Bank and IMF policies such as the imposition of user fees for primary health care and primary school "policies which disproportionately harm people who are poor and vulnerable such as orphaned and vulnerable children. Congress has already taken important action to oppose the imposition of user fee policies by the IMF and the World Bank as a part of debt agreements or new loans. Treasury must ensure that this policy is enforced.

Bipartisan US Congressional action is urgently needed to ensure that a "New Deal on Debt to Combat HIV/AIDS" is approved when the G7 leaders meet in Genoa, Italy in July, based on:

- Complete cancellation of the debt owed by the world's poorest countries enrolled in the HIPC Initiative to the International Monetary Fund and the World Bank is affordable to these institutions without affecting their international credit rating or lending ability and with no cost to the American taxpayers;
- Immediately halt and oppose all World Bank loan programs designed to fund the recurrent costs of HIV/AIDS programs in heavily indebted poor countries, as these programs perpetuate and exacerbate the debt crisis;

- Inclusion of more countries in the debt cancellation process;
- Congressional action is required to enact the "H.R. 1567: Debt Cancellation for HIV/AIDS Response Act" that was introduced by Congresswoman Barbara Lee and is supported by 13 Members of Congress from both sides of the aisle.

CONCLUSION

Arnold Toynbee, a famous American historian, stated that, "The 20th century will be chiefly remembered in future centuries not as an age of political conflicts or technical inventions, but as an age in which human society dared to think of the welfare of the whole human race as a practical objective."

Mr. Chairman and Members of this Committee, as elected officials representing the American people and American values, you in partnership with other World leaders—have the power and authority to ensure that debt cancellation and sufficient grant resources are provided for an expanded and comprehensive response to HIV/AIDS pandemic. Your actions can literally save millions of lives around the World.

So Mr. Chairman and Members of the Committee, with the advent of globalization, the information revolution, the science and technology revolution, and our unprecedented wealth and budget surplus, we undoubtedly have the tools, tactics, and resources to stop global AIDS now. I ask you and all of the Members of the Committee to consider the question, "Can we miss this opportunity and responsibility to ensure that the 21st will be recalled as the century when human society—with a strong American partnership—achieved success in stopping the global AIDS pandemic?"

Mr. SMITH. Dr. Zeitz, thank you very much for your testimony and for your recommendations.

I would like to just ask a few opening questions and then I will yield to my colleagues.

Ambassador Seck, would you expound upon how Senegal has been able to cope with the HIV/AIDS pandemic and how your country might serve as an example to other African nations and other nations around the world. You mentioned in your testimony several cultural norms, including the small percentage of extramarital affairs, the low percentage of premarital sex, and religious observance. Is that it or are there more and how does that all work in a positive way to keep your nation as free of this terrible epidemic as possible?

Ambassador SECK. I think that first information has a big role, education has a big role, but demystification about what we think is privacy. That is why I say that the Africans have to do something by themselves because I think that a doctor coming from outside does not understand that cultural problem. That is why we have to work together and I think the help we are asking is not about money only, but partnership first.

The CDC working with those Africans, for example, the Africans have a kind of experience about HIV that maybe we are not sure to find in the CDC. I think that exchange, like the exchange of information between our national team with the Medical School of Harvard University could help, I think.

But also as I said, as a democracy, we cannot close our borders. If we have a prevention of 1.5 percent and next door is 10 percent, the Ivory Coast, for example, we have to do something. And we hope that our friend will not say you have a success story, we will let you continue and we are going next door. We have to do that together.

Mr. SMITH. Could I ask all of you what role you think corruption in leadership, the role of war as we have seen in Sudan and the bloodshed that has occurred in the Congo, we know that corruption

is robbing emerging democracies everywhere of their vitality. It even lends itself further to the coverup and the inability, cultural or otherwise, to be completely transparent about the full scope of the problem.

And it seems to me, you know, people often complain about Congress being the best Congress money can buy and we are often criticized and some of that criticism is justified, but it seems to me it goes into a whole new level when people's lives are being lost because of that corruption. I mean, Suharto who is now obviously gone, but many others who horded money and brought their countries to ruination; meanwhile, they have these epidemics rising and they just put it aside and act as though it does exist. Where are we on that and how do we correct that and what role does that play, if you would like any of you to take a stab at that?

Mr. Ambassador?

Ambassador SECK. I am convinced that we have no development without stability and peace. That is very true. But also I have been a soldier for 33 years along with my good friend Colin Powell and I know the cost of a war. I think that in the war not only you lose the money and the human dignity and everything, but at the same time the soldiers are spreading this kind of disease because it is an STD. That is very important, Mr. Chairman.

Something else about corruption. Sometimes I have the impression that corruption in Africa is exaggerated. I am not saying that it does not exist. Last year or 2 years ago, Vice President Al Gore convened a meeting here in the U.S. where all the continents were represented. I was struck by the modesty of the members because everybody came not to give lessons, but to say that there is corruption in their own country. I remember that the same week the *Wall Street Journal* was mentioning big corruption in Europe, for example, because corruption has to do with temptation for a human being that could be Senegalese or somebody else. But still we have to fight it.

Now, sometimes I have the impression that people think that we all, our leaders are all corrupt. That is not true.

Now, something else about AID, the role of AID, AID and the Peace Corps are not giving money to the government, for example. When I was a young pilot 30 years ago, I remember going with these people to carry them to the rural areas where there is no intermediary. Of course the government—these people have tires and air conditioning and everything, but this kind of cooperation is at the grassroots level. That is another solution, I think. Thank you.

Mr. SMITH. Yes?

Mr. DOKMO. Mr. Chairman, I would just like to add that obviously corruption and war destroy civil society, but what we have seen through microenterprise development programs is the money goes straight to the grassroots—to the very needy people who have a chance and will have hope. The very essence of the war, which is often joblessness and so forth, will be minimized as people have gainful employment. And so we have seen in Russia, there is great instability, great corruption, but with their programs throughout the former Soviet Union and Russia, you've got some very exciting

stories to tell with communities being stabilized and corruption being brought under control.

Mr. SMITH. Yes, Dr. Zeitz?

Dr. ZEITZ. Thank you, Mr. Chairman. I would like to refer to my statement where I mentioned a specific recommendation for what we call an international drug and commodities anticorruption program. Clearly, there is corruption going on in Africa in the drug and commodities sector and if we are going to get the condoms and the drugs for treating STDs out there, treatment for malaria and TB, et cetera, we believe that we as an international partnership need to come together and focus on the drug and commodities sector corruption.

This is institutionalized in many countries and by working on it together in partnership we could make real headway. That is an essential ingredient for any health objective that we might have in Africa, with Malaria or TB or anything.

Second of all, there are some exciting mechanisms that have been established on the continent that have included civil society anticorruption schemes. The best example is Uganda. It has a poverty action fund which is a central basket of funds which goes directly to the district and community level. What happens is civil society monitors the use of those funds and reports on its appropriate use. And some innovations have emerged from that. For example, when the mothers were finding that the money for the school improvement was not having any effect, they started doing research and they developed two innovations: post the budget of the school at the school and publish it in the newspaper. And by doing those two things, it transformed the national education program. So civil society accountability mechanisms can work if they were expanded and invested in.

Thank you.

Mr. SMITH. Thank you.

Yes?

Mr. SCOFIELD. I think a reality of the developing world, unfortunately, is that institutions are very weak in many countries and the justice system is very weak. There is not much castigation of naughty people, particularly in high places.

Personally, I was impressed by the recent steps taken in Mexico where the wages of the police force were tripled or quadrupled. I think that is going to have an enormous impact on the corruption problem. Because we have to face reality, people are living on a few dollars a day—the majority of the population. They are putting their families before anything, before any kind of high ethical standards or whatever. They have to survive. So the temptations are enormous.

I would say as a guideline you need to work with institutions that have a track record of accountability. They can be government agencies, they can be NGOs, they can be international organizations, but they need to have a track record of accountability and transparency or you put your commodities or your resources at risk.

Mr. SMITH. Yes?

Mr. HAYES. Mr. Chairman, in fairness to Africa, it takes two parties for corruption. I think not only the taker but the takee, I sup-

pose. The issue, in terms of the American corporate sector, I think the American corporate sector follows the guidelines set by the Government Corrupt Practices Act, which I think is terribly important, far better than other developed countries' companies. One of the key incentives for American business, or one of the opportunities or something that would help American business, is in fact to see that those same guidelines or practice acts are applied to the European companies as well as Asian companies. And so I do not think it is simply a matter of in-country practices. It does take all parties. However, we also do realize, and I think it is why companies need to be continually encouraged to work together with one another—because what they are doing in terms of the subject of HIV/AIDS is very valuable. We need that support and it is also why I think it is important to have a cross-section of the sector working together. It makes it much easier to avoid corruption.

Mr. SMITH. Let me just ask one or two questions and then I will yield to my colleagues and they will be entitled to whatever time they would like to consume.

One of the issues that I have worked on very hard and this Committee has worked on for a number of years is the whole issue of trafficking. Last year we passed—I was the proud sponsor of P.L. 106–386, the Victims of Trafficking and Violence Protection Act, a mammoth, comprehensive attempt to really help the women, most of the women, who were trafficked and also to prosecute those who were in either countries of origination, transiting or destination, anyone who facilitates the trafficking of individuals.

Recently, my wife and I were in Italy and we were meeting with parliamentarians from Italy. They are working on draft legislation themselves and we are always trying to exchange what works. Well, they have been cracking down on their own Mafia. Many of the women that are trafficked out of Africa from Nigeria are sold in some cases by their own family members, but in other cases they are orphans. And I am wondering, with this huge exponential increase in orphans in Africa, are they not ripe for this additional exploitation? Not only have they lost mom and dad, now they are susceptible to being either slaved as chattel in Sudan or trafficked out of the country or intercountry in Africa for purposes of indentured servitude or forced prostitution or some other kind of wrongdoing.

And, again, another consequence of the AIDS epidemic and one of things I would like to see more of, and you might want to comment on this, is in the area of adoption. We do too few adoptions out of Africa. We recently passed legislation implementing the Hague Intercountry Adoption Act to facilitate more adoptions and to make it more definitive so the red tape is mitigated. It seems to me that a lift of children who are adoptable in Africa is something we need to, I think, move into much more.

And, finally, I would just note for the record, last year Mr. Gilman had an important bill dealing with microcredit, providing $155 million each year over 2 years, it was fully appropriated. Is that enough? Because I happen to be, like I think both sides of the aisle on this Committee, a staunch supporter of microcredit. It's getting almost like our immunization program, for pennies we can make a difference in someone's life. You know, the old adage, give them

a fishing pole and they can feed themselves, give them a fish and they eat lunch.

I really think it is a great investment, but is $155 million enough? Do we need to ratchet that up?

Mr. Hyde's bill integrates, it does not give an exact amount, but it integrates it in a full-court press.

And, finally, answer and then I will go to my friends, Mr. Hayes, I do know that some large companies like Coca-Cola and Ford are offering AIDS prevention programs to their workers. Is that something that is on the rise, where corporate America and corporate Europe and others are realizing that it is in the interests of their employees and their own financial interests to be more proactive education and treatment?

Mr. HAYES. I will be glad to start on that second half of your question.

Mr. SMITH. And the trafficking, too, if you would touch on that, gentlemen.

Mr. HAYES. Clearly, it is on the rise. It is not simply Coca-Cola and Ford. Ford is perhaps doing some of the best medical work among corporations that we have seen so far. We have interviewed a lot of companies in regard to our upcoming task force report.

Again, what we found is that many, many companies are doing AIDS programs within the workplace, but they are not aware of what other companies are doing and in many cases, in the case of this bill, they are not aware of what the AID mission is doing in their own country, in the country in which these corporations are operating.

So there is a great rise and it is simply from a very practical point recognizing that prevention programs that they are doing are going to actually increase and not decrease profits; the more that is spent on prevention, the less that will have to be spent on treating the disease itself.

So, yes, it is rising throughout, but, again, I think what we are finding is that companies sometimes are reluctant to talk about what they are doing because of the atmosphere of a particular country, the country's leader's statement. If they talk about their prevention programs in some countries, it actually hurts them more than helps them.

So what we are finding is that it is sometimes difficult for companies to talk openly, which is a sad case, but true, openly about what they are doing but more and more companies are coming on and we hope with the task force report we will open it up to thousands of companies around the world.

Mr. SCOFIELD. I would be happy to address the question on microfinance and, actually, Mr. Chairman, it is interesting to me, 15 years ago I testified before the Committee to actually get the microfinance movement going, get its initial financing and support from AID, and we had this same issue of capacity. And it is a real issue, we should not minimize it. My conclusion, in light of our experience where we went from almost ground zero up to about 20 million worldwide beneficiaries or clients of microfinance today, if you put the resources there and you make them available, people will use a part of them to create the capacity and the rest to expand.

So I think certainly from FINCA's experience, we have an ambitious strategic plan where we are going to be trying to raise $60 million over the next 5 years just to meet our own needs for expansion. There are thousands, literally thousands, of these microcredit organizations worldwide who are doing good work like Opportunity International and, you know, obviously AIDS is a huge priority, there are many needs, but certainly microfinance I think is a part of the solution.

Ambassador SECK. Maybe I can say something about microfinance. In my country and in many countries in West Africa, we have what we call the tontine. It is the kind of microfinance where 10 people, 20 people could give maybe $10 each. We have two solutions: either you give it somebody to realize something of a business, or we give to somebody for the whole group.

I think what we need in the microfinance is to modernize it, to have the documentation. Mostly they are women. And we see that the banks like those kind of microfinance because we have 90 percent of these women reimburse all the loans. Since this is also about very small sums like $50 or $100, these people are empowered and they become really citizens and economically there is development and also health care for the children. And mostly we see that their children are going to school.

Thank you.

Mr. SMITH. Mr. Dokmo?

Mr. DOKMO. Mr. Chairman, I would agree with my colleague from FINCA. As we have looked at the numbers, we believe the microenterprise community could use well over $200 million to build economic keel under the HIV prevention and curative portions of these activities. The roots have very strong economic roots, if you will, and it is our conviction that we would like to leverage some of that money with other sources, with corporate sources and other public sources, that we could find to maximize our impact.

We would like to use government guarantees to leverage both from the U.S. and in other countries to leverage these monies so we can maximize our total amounts of capacity to help these very poor families.

Mr. SMITH. Yes, Dr. Zeitz?

Dr. ZEITZ. Thank you, Mr. Chairman. I would like to respond to your question about the orphans. I would like to submit for the record a report called "Children on the Brink." It is a USAID report which is probably the best evidence and projections on the orphans crisis that we know of. Clearly, it is an explosive problem.

In terms of in Africa, our analysis is that most of the issues around orphans focus on the children as a child labor force being exploited within the country itself, so I think there are some serious issues about that. There are places around the world like Nepal and Myanmar, where trafficking is becoming a larger problem, so I think we have to look at it geographically and develop strategies in that regard.

In terms of adoption, when one looks at national orphan policies in Africa, one finds that, in Southern Africa, especially, the legal framework that dictates the rules about adoption and so forth was inherited from the British colonial rule. So a lot of the rules and legal framework surrounding orphan response are exceedingly out-

dated and need to be modernized. There are specific proposals for how to incorporate a legal reform approach to promote adoption and other things like that as part of an orphans response.

I also wanted to mention on a personal note that my wife and I adopted a 13-year-old Zambian son. We are having problems getting through the bureaucracy in the United States. We got it through the Zambian bureaucracy much quicker. So I think that there are still some outstanding issues in that regard.

Mr. SMITH. If you could provide the details to the Committee, we would look into it for you.

Dr. ZEITZ. Great.

Mr. SMITH. And I am serious about that.

Now, let me just ask for the record if you have any further insights on the corruption issue mentioned earlier because we have seen in the breakup of the Soviet Union and the emergence of corruption as a major detriment to democracy and human rights. As a matter of fact, it is going in the opposite direction. The organized crime elements, large and small, and many of them are large, have stepped into the breach so that trafficking is now in drugs, and guns, the number three moneymaker. And we keep hearing of more and more Africans being trafficked, often intercountry and in Sub-Saharan Africa, but we do not have the basic information. I think it is a crisis that needs to be further looked at. So if you have any information on that, please provide it.

And I learned of the Nigerian situation in Italy and was kind of shocked at the numbers. It was much higher than one would have anticipated.

The Chair recognizes the gentlelady from California, Ms. Lee.

Ms. LEE. Thank you, Mr. Chairman.

Let me first ask Ambassador Seck, you heard Mr. Natsios' testimony and I just want to hear your take as an African. I want to hear an African perspective on this whole concept of time and what he mentioned with regard to the difficulty as a result of the lack of infrastructure and to the dissemination of medications. What have you, because it appeared the lack of cultural understanding was pretty prevalent and I do not want to see that driving our policy. But I have been going to Africa for many, many, many years and have been in the urban areas, rural areas, mountains, seaside, villages.

I never have experienced or noticed any difficulty with the time thing and maybe that is because I am of African descent. But I was very surprised to hear that raised as a real—that it could be—a real reason for us to be more focused only on prevention. At least more of a priority should be given to prevention rather than look at this in a multifaceted approach because we cannot seem to figure out how to do these things in Africa.

Ambassador SECK. It is true. Mr. Chairman, let me first commend you for your role in this piece of legislation about AIDS in Africa. Thank you for your role.

Now, coming back to the assessment, lack of infrastructure, no roads, etc. Of course, I do not agree. It is true that we do not have the same network that you have in the U.S. As I said, I used to be Air Force pilot. Twenty years ago, to go to Kedugo in the eastern part of the continent, we mostly used the plane. It was expen-

sive, the medivac, those kinds of things we used to do that by plane. But for the last 20 years, we use the roads. It is less expensive. And when you go on the inside, people from the Peace Corps and AID know those villages and they go by jeep, for example.

So, of course, everything is diverse in Africa. The continent of Africa is four times the size of the U.S. In the African continent, you can comprise all of India, China, Western Europe, Argentina. My country, Senegal, is closer to Myanmar than to Zanzibar, for example. The people do not realize that Africa is not one country in one place. There is a lot of diversification. So many countries, of course you cannot compare, for example, the network in South Africa and what is happening in the Sahara, but many countries have some kind of infrastructure.

Now, coming back to the cultural obstacles. In Senegal, we overcome this by explanation. That is why information is very important. For example, using the TV, when people are illiterate, you do not need to write, you just have to show them. This kind of media, we use them to educate people.

When they said, for example, do not talk openly about sex or condoms, that means that you allow your kids to have sex, extramarital sex. We used to say no, because that happened anyway, especially in the urban areas. So you better prevent and protect these people, especially when we know that in the 1980's and in the 1990's there are some countries in South Africa where in a family of ten, two or three children are lost to HIV/AIDS. That is what we use as an example.

Ms. LEE. Thank you very much, Mr. Chairman. I think this is very important in terms of our policy toward Africa and toward addressing this HIV and AIDS pandemic. I think we have to look at African centered or African oriented solutions to many of the problems and I would hope that out of these hearings we realize that. I do not want to see us saying that we are not going to be providing treatment and medications because Africans cannot tell time according to western notions of telling time.

Ambassador SECK. No. That is an exaggeration. I think that—I was in the military, 8:00, that is 8. That is not 8:01. We have a very professional army. So that is not true. That happens everywhere. You go to Mexico, also, people say that because they are in the sun, people are always waiting, they are late, they are lazy, that is not true. That happens sometimes everywhere.

Ms. LEE. Thank you.

Ambassador SECK. Congresswoman, you were not there when I said that in our country we have already a national plan against HIV/AIDS since 1986. AID came and was integrated in our national policy. I think that is the best solution.

Ms. LEE. Right. Thank you very much.

Let me ask Dr. Zeitz a question with regard to this U.N. General Assembly special session on HIV and AIDS. What is the scuttlebutt with regard to this now in terms of U.S. participation, in terms of formulating the declaration, and in terms of the debate with regard to treatment versus prevention and the whole issue around drugs?

I mean, do you have any information on this in terms of what we need to know? Because I think this is a very important session and I—again, it is scuttlebutt I am hearing—but I would like to

know if you have any clearer understanding of what is going on at this point.

Dr. ZEITZ. Thank you, Congresswoman Lee, for that difficult question. What I can tell you is that we are in contact with a number of civil society groups that are closely monitoring the deliberations. There was a prep com meeting that was held over the past 2 weeks where government delegations from around the world sat and word by word reviewed the draft declaration and modified it.

It seems that there are three major outstanding issues where the U.S. apparently is playing a key role in keeping these as outstanding issues. The first is human rights language. Most country delegations would like the declaration to explicitly state that access to medicine and access to an appropriate AIDS response is a human right. Apparently, the U.S. is against incorporating this as a human right, although I cannot speak for the U.S., I am not exactly sure——

Ms. LEE. But that is what you are hearing.

Dr. ZEITZ. Yes. That is what we are hearing. Yes.

Ms. LEE. Okay. That is what I am trying to find out.

Dr. ZEITZ. The second issue is around the access to antiretroviral medications. There is some opposition about promoting the use of generic drugs.

Third, there are a number of delegations, possibly including the U.S., although I am not 100 percent sure, that are concerned about listing issues related to specific vulnerable populations, including men who have sex with men and sex workers. And there is some opposition to addressing the needs of these special vulnerable populations explicitly in the declaration. So we understand that there are still some ongoing negotiations that are going on.

I would also like to comment for the record that the involvement of civil society was haphazard and less than full, if you know what I mean. There are experiences from Cairo and other international conferences where civil societies were all—where it is very well established, well managed, well articulated and well incorporated into these international statements and processes. In this process, I think most civil society members feel like it was a less than optimal involvement.

Ms. LEE. I see. Well, thank you very much for clarifying the scuttlebutt.

Let me ask one more question with regard to debt cancellation and I guess I would like to ask this of Mr. Hayes and Mr. Dokmo and Mr. Scofield.

In terms of using the debt service that these countries are saddled with and direct them into HIV and AIDS prevention, education, infrastructure, capacity building and also microenterprise development. In listening to you, you recognize that the empowerment of women is really essential in dealing with this issue. I am thinking that with regard to our debt cancellation bill that one of the strategies we would want to see would be, of course, microenterprise development as an HIV and AIDS prevention strategy.

Do you think that this makes sense in terms of the multilateral organizations seeing this as a possibility and a vehicle for them to step up to the plate, cancel the debt, use this money for such efforts?

Mr. SCOFIELD. I think in our case, and probably my colleague from Opportunity International would agree, we strongly feel that microfinance belongs in the private sector. That it needs to be administered not by governments, but by institutions, whether they are national or international, particularly because of the huge temptation to use debt relief as a political tool. And that, of course, would destroy the microfinance institution and its whole sustainability and so forth.

I am assuming, I guess, in my answer that we would be saying that the funds that normally would go to debt service by the government to the World Bank or whatever would be put into a government microfinance——

Ms. LEE. No, I am saying into the private sector.

Mr. SCOFIELD. Oh, okay.

Ms. LEE. Into allowing these resources to be used for microcredit, for these businesses that emerge.

Mr. SCOFIELD. Yes, I think that certainly could be a viable option, I would think.

Ms. LEE. Thank you.

Mr. Dokmo?

Mr. DOKMO. I would strongly agree with you, Congresswoman Lee, that this is a terrific idea. We have been working through our advocacy at different levels to promote this and we are wholeheartedly supporting it. We need to maximize the number of dollars that really help our women and I think this is the best vehicle that we have. It goes straight to the families and it is a tremendous impact.

Ms. LEE. Thank you very much.

Mr. Hayes?

Mr. HAYES. Yes. Our members basically are in favor of debt relief, obviously, for very practical reasons. Again, the less on debt payments, the more that can go directly into the economy. It also stands to reason that a healthy population makes for a healthier economy as well, so this is certainly one area that we would be in support of.

Ms. LEE. Thank you very much.

Thank you, Mr. Chairman. I will stop now.

Mr. SMITH. Thank you, Ms. Lee.

The Chair recognizes Mr. Payne, the gentleman from new Jersey.

Mr. PAYNE. Thank you very much, Mr. Chairman. Unfortunately, my schedule prevented me from being here to hear the testimony of the previous persons and most of you here today. Although I was not here, I did hear that it was mentioned that people did not have time straight or could not follow that, so I just want to make it clear I knew what time it was myself, I just had some visitors and students and others and was unable to get here, but I just really wish—and I looked through the testimony because when I do miss hearings I try to see whether this was taken out of the text, I have not seen it yet, maybe I am reading the wrong person, was it the new AID administrator?

Mr. PAYNE. Well, I guess we could look forward to a lot of progressive stuff with USAID.

I would just like to, first of all, congratulate, Ambassador, your country in its recent election where we did not read much about

it, but in a country when a problem happens in the presidential election and a military coup takes over, of course, that gets all the news, but we did hear very little about the peaceful election, the losers congratulating the winners and government proceeding.

Let me just ask a couple of general questions.

Do you feel that with the African leadership, presidential leadership, executive leadership and legislative leadership, do you feel that—and I met many of the Presidents at the millennium meeting at the United Nations a year ago or maybe 8 or 9 months ago, as a matter of fact, Mr. Hayes and the Corporate Council on Africa sponsored a number or those meetings and I heard a number of Presidents get up at a public meeting to talk about the problem openly and what they were doing.

In your opinion, this notion that most African heads of state are not discussing the issue or not dealing with it still persists and I wonder if you could clarify whether there has been a more positive movement in the last 3 or 4 years than previously, and whether many of the American and European organizations are still back 4, 5, or 10 years ago when there was a denial or lack of affirmative action relating to that.

Could you tell us the current climate relating to that?

Ambassador SECK. The climate as vis-a-vis the HIV/AIDS?

Mr. PAYNE. Yes. And the leadership of the countries dealing with it head on.

Ambassador SECK. I think that 5, 10 years ago many countries were thinking about, for example, tourism. If you decide that there is some kind of prevalence in your country, people are not coming. I would say with information and transparency people know what happens almost in every country. So nobody is saying any more there is no HIV/AIDS.

The problem is about statistics mostly. They are saying you have double-digit, 12 percent; some are saying 7 percent; this is where the problem lies. I think that we cannot hide anymore that in many countries, even in West Africa and even in the Sahara, we still have some degree of HIV and with the media, with the television, with CNN, you cannot hide those kind of things. And that helps even in democratization because by definition democratization means that you cannot hide anything, everybody knows. That is why, for example, last year the Organization of African Unity (OAU) decided that if somebody has a coup d'etat, they will not be accepted by the head of state any more.

Those kind of decisions could help, I think, but also we ask the leaders of the world, like the U.S., to help us provide this kind of information everywhere, in CNN, to just how the real reality, the reality everywhere. But not also to generalize the negative image of Africa, but what is a success story also must be publicized. Thank you.

Mr. PAYNE. Thank you very much.

Mr. Hayes, I know of your work with the Corporate Council in Africa and your work many years ago working in developing countries 20, 30 years ago, 35 years ago. How do you approach businesses, I know you may have covered it, as relates to the current problem and to attempt to get the companies that are involved in Africa to have that as a component of their business plan?

Mr. HAYES. Very frankly, many of the companies already do have a component in their business plans. Not all do and we are also concerned. We are encouraging more companies to become involved in Africa and one of the ways to do that is demystify the fear of the AIDS epidemic.

So we are coming out with a report that will be very public, very shortly encouraging a look at best practices for corporations in dealing with the problem, showing that the problem exists. But it is not insurmountable, and encourages corporations to enter into cooperation with civil society groups, intergovernmental groups and certainly the national governments.

We also have some very good examples in those best practices where companies such as Haliburton, for instance, to go back to Congresswoman Lee's comments to culture, there are cultural effects and differences that do affect how things happen. We are working, for instance, in distribution, we work in education, particularly, work with the local leadership of a village, as opposed to just going directly in that regard.

So, again, one size, one way, does not fit all. We are working in a variety of methods and really trying to work very hard dispensing information, education through multiple channels.

Mr. PAYNE. Thank you. Let me ask another question, anyone else can also contribute.

I think you raised the issue earlier about corruption and we have heard—evidently, that was one of the problems suggested. Transparency International is a relatively new organization that is finally bringing up the whole question of corruption that is being raised. I met with the E.E.U. last year and brought up the fact that corruption's time has come and past.

As you know, in Germany, the fees for bribes and corruption are deductible as a business expense. You just have to put down how much bribe you did and that is just a cost of doing business. In other countries, certainly the practice is allowed. I mean, it is not necessarily tax deductible in all of the countries, but I do know it is in Germany.

Has this issue been raised with your companies? Because, as we know, it is against the law in the United States and you can go to prison for corruption. Is this discussed at your group and with your counterparts abroad in Western Europe? Primarily, are there any initiatives taken on the part of U.S. companies to companies in Europe about this issue or is it raised. Also, do you participate with Transparency International?

Mr. HAYES. We are entering the dialogues with a lot of different groups. We have not yet entered into dialogue with Transparency International. I would welcome that.

I am also on Kofi Annan's global compact policy dialogue in New York. As a member of that team we are involved with Transparency International and many other groups. I think that type of dialogue is absolutely essential.

Often, the greatest obstacle to American business in Africa is not necessarily the corruption issue but how other countries are dealing with various members of government. Our problem often is, again, not the Africans as much as it is the competition in Europe and the old colonial patterns.

I am encouraged by the African countries now more and more saying they want to break away from that. If Ambassador Seck will forgive me, that even Senegal wants greater involvement with U.S. businesses and less so with the colonial past.

So we are encouraged by what we see in that regard.

Mr. PAYNE. Very good. Thank you.

Mr. Scofield, could you—you have been involved with the program in Uganda and that has been talked about. Are other African countries to your knowledge visiting Uganda in general and HIV organizations trying to replicate what is being done there?

Mr. SCOFIELD. I cannot really speak—if you are speaking on the AIDS front——

Mr. PAYNE. Right.

Mr. SCOFIELD. I really cannot speak to that, unfortunately. I do know that there is a lot of exchange, at the level of central banks and so forth among African countries, about microenterprise and how to create an enabling regulatory environment and replicate the success of the Uganda experience. We actually foresee many benefits of that in other countries we work in, including South Africa and Malawi and Tanzania.

And I have to say a good word on behalf of the African continent in terms of corruption and it may just be a relative compliment. But compared to the former Soviet Republics where we and our people are approached almost on a daily basis for bribes and so forth, from tax police and so forth, it is just constant harassment. Not so much of FINCA's institutional people, but our clients get approached 24 times a year, almost like a regular payday.

In Africa, we do not have that problem and so it is a much more favorable environment for what we do, microfinance.

Mr. PAYNE. Thank you.

Yes, Mr. Dokmo?

Mr. DOKMO. Congressman Payne, I wanted to let you know that Opportunity started a program there, it was a result of FINCA's leadership in terms of piloting a similar program in Uganda. It is a great place to pilot this. And we are very much tied in with the Microcredit Coalition and the Microcredit Summit, which are looking to disburse best practices in this area. So it is a very important thing that we transfer these best practices across the board to all the agencies who are making a difference in their local communities.

Mr. PAYNE. Yes, Ambassador?

Ambassador SECK. Yes. Since everybody is talking about corruption, may I just tell you that we have many VIPs in jail in Senegal. After the elections, we asked for some audits of all those big companies, mostly state-owned companies that we tried to privatize. I think there is maybe 20 VIPs in jail now. Thank you.

Mr. PAYNE. Thank you very much.

Well, let me just conclude by saying I really appreciate having the opportunity to be here. Like I said, when I heard about the time problem, I really just canceled the rest of my things, I said let me get down there and see what is going on, you know, I was just beside myself. And if anyone is here, I guess, from that person, maybe we can have an opportunity to—maybe I can get a private

one-on-one meeting on this, on the watch and the lack of them and clocks and that.

I do think that, though, there is a problem with the lack of the urgency that the U.S. has taken in leading the world on the problem of HIV and AIDS. I think that it is a global problem and corporations and foundations and governments and organizations have to become involved, but I think that the lead should come from the U.S.A. and the 200 million pledged recently by the current Administration I think is disgraceful.

The fact that someone said it is about 6 percent of what it should be, I thought it should be several billion, 2 or 3 billion as a goal. Even worse than that, I understand that the 200 million that has been pledged is going to, I guess, come out of some of the development funds in some other countries, rural development fund for Africa, kind of scratch around and try to get a little money here and a little money there, to come up with the 200. So it is even worse than robbing Peter to pay Paul. It really shows a lack of leadership, a lack of concern about the pandemic.

It is embarrassing, giving back $1.35 trillion to people that do not need it, to then say we could come up with $200 million over the next 10 years to fight the pandemic on AIDS is just absolutely disgraceful and I hope that we can rethink that.

I was in Botswana recently and did meet with the Gates Foundation, people who put up $50 million themselves over a 5-year period, and with the Merck Corporation that is in a program with the government of Botswana. It is a little slow getting moving, but I think that it will be accelerated and the Botswana Ambassador was saying the same thing, it needs to be integrated into what they are doing so that it can be a Botswana model, but with the resources from the Gates Foundation and the Merck Pharmaceuticals.

Also, The Discovery Channel is getting involved and would like, as a matter of fact, Ambassador, to meet with the African diplomatic corps to talk about the way that they want to deal with the education part of AIDS because of their long distance learning and the way they have been able to tie education to solar energy and get back into rural areas. We had Dr. Ipsham from the Discovery Foundation appear before our Subcommittee recently and talk about how they are doing in certain countries, so that is something I would like to also explore with you and.

I would just like to once again thank all of you. We have seen you UNACR, which needs to be dealing with transit people where HIV and AIDS can be spread, as you mentioned, in the military and in other places. They have been underfunded by about 18 percent and had to last week reduce the overall staff of UNACR when the U.S.'s donations fell off and other followed suit.

And so we just see time after time where we have the ability and the capacity to do more in leadership. I think it was unfortunate that we were voted out of the human rights group, especially with some of the countries that are in there, but I sometimes, you know, wonder how far we can go before people start saying, well, you know, you are really not showing the leadership you ought to and maybe this ought to be a wake-up call to take another look at yourself.

Sometimes you need to get an opportunity to internalize what is going on because the world is changing and the way we deal with the world is changing. I think we should be on the human rights caucus, but when we look at a number of the issues that we have failed to do the leadership we can do, I think it might be just a message to say why do you not really use your resources as you can and so I hope that we continue to try to catch up on our late dues and do not hold those back, as they have threatened to do.

Anyhow, I am glad I got here. I am sure not everyone is glad I got here, but I am glad I got here.

Thank you very much.

Thank you, Mr. Chairman, for the extra time. I yield back the balance of my time.

Mr. SMITH. You may want more time in a minute.

Let me just make a point to my good friend from New Jersey, and we have worked together on a number of humanitarian issues over the years. I think it ought to be pointed out that more resources are spent by the U.S. on HIV/AIDS internationally today—without the new money, without the new Hyde bill—than any other nation's donors combined, including the United Nations, international relief organizations, and developed countries. That does not mean we have done enough, but it does mean that we have certainly exercised leadership. I would just say to everyone and I think the record needs to reflect this, I was the prime sponsor of the Foreign Relations Reauthorization Act last year. That bill made up of over 100 disparate provisions. We put more money into the UNACR than Clinton asked for, $50 million more. As a matter of fact, people kept saying he does not need the money. I said we are awash in refugees, he can use the money. We put $50 million more each year for the UNACR which gets much of that money that is in the refugee account.

We also plussed up account after account after account. Again, I think we have shown leadership.

Yesterday, we spent 5 hours or so in the Subcommittee on International Operation of Human Rights, chaired very ably by Ileana Ros-Lehtinen, and it came out very, very clearly during that hearing that this is part of a pattern when we talk about being thrown off the U.N. Commission on Human Rights. They do not like the fact that we raise country-specific, especially China specific resolutions. WEOG, the group that we are a part of with the European Nations, are loathe to name countries when it comes to human rights and it is also part of a longer standing drive to move us off.

It was pointed out by Ambassador Kirkpatrick that in 1994 we lost our seat on the U.N. Commission on the Status of Women. That was in 1994, when the so-called arrearages issue was nowhere to be found.

Finally, on arrearages, and I want the record to show this very clearly. We provide approximately $2 billion to the United Nations every year in assessed and voluntary contributions, most of which, three-fourths, we do not get credit for. When you add in peacekeeping, airlift capabilities, when you add in UNICEF—and Mr. Hyde has in his bill which just passed the House $120 million for UNICEF—we are all behind that. That is more than last year,

more than the year before that, more than the year before that. That is the way it ought to be. Well, we ge no credit for it.

So when they talk about arrearages, it is for disputed accounts like the much flawed U.N. deployment which was in an atrocity. I will say that anywhere, anytime, what we did or allowed and we facilitated some of that money for U.N. when the people in Srebrenica were being murdered and the blue helmets stood by and facilitated that. I have held hearings in this room time and time again on that. That is what we were being told we had to pay some of this arrearage for and a very significant amount of that arrearage.

So the arrearage issue often becomes a pretext, in my opinion, for just saying, oh, that is why we have lost—we are real leaders, we lead with principle. Hopefully, it is always bipartisan, and I am proud of that. And we can always do more and hopefully we will be doing more. That is why we have this hearing going on today.

Mr. Natsios made the point earlier in this hearing that the $200 million is new money. It is not a reallocation of accounts, it is new money. I think it is important that that is the case because we have all been snookered in the past by just drawing down on spigots that were already being used and then you just say, oh, now we are providing this. No. This is new money and he made that very clear in his testimony today.

I know Ms. Lee has a question and then I have one final question and then we will conclude.

Ms. LEE. Thank you, but may I first comment on what you just said, please?

Mr. SMITH. Sure.

Ms. LEE. I believe that Mr. Natsios with regard to this $200 million said that they are taking $100 million from HHS, Health and Human and Services. What accounts over there they are taking it from, I do not know, but it could be from our domestic AIDS account.

He also indicated that $20 million is the $20 million that we authorized last year for the World Bank AIDS Trust Fund. The balance, he indicated, was coming from the reserves over at State Department which I understand could go as far as U.N. peacekeeping and other accounts that we desperately need. So I do not believe he indicated this was new money.

Mr. SMITH. Would the gentlelady yield?

Ms. LEE. Yes.

Mr. SMITH. We are talking about unused funds. We are recovering funds that have been unexpended and unobligated for other accounts, taking them into a new AIDS initiative and putting it into that. So it is brand new, never before used for this purpose. And like the Health and Human Services money, that is recoveries, monies that we have gotten back. They would not have been used for AIDS otherwise.

Ms. LEE. Well, it should have been used. And let me just say on the fact that we have spent whatever we have spent on HIV and AIDS in terms of our leadership role in the world, I think that we probably have spent these meager resources, and I consider them meager considering the nature of the pandemic, in the last couple of years, but the CIA knew about this pandemic 20, 30 years ago.

The Reagan Administration knew about this pandemic and did nothing about it. So we have a lot of catchup to do in terms of resources, just to be able to begin to scratch the surface of being the leader in the world on this.

Let me just ask Dr. Zeitz my final question with regard to the orphan crisis because I have visited, again, many times and seen this orphan crisis and it is mind-boggling, it is staggering, this is a whole continent of children that could be wiped out. In Africa, however, I know that family reunification is very important also. So our strategy in terms of adoption mitigation, does it make sense for us to look at family reunification and helping families develop a social infrastructure rather than looking at adoption initiatives in the way we look at adoption initiatives here?

In addition to that, the provision of HIV and AIDS medications for mothers to prevent the mother-to-child transmission, I mean, is that not a part or should that not be a part of an adoption mitigation strategy or an orphan mitigation strategy?

So I am wondering in terms of our strategy with regard to how we approach children with our mothers or fathers any more, how should we be doing this so that it makes sense in Africa?

Dr. ZEITZ. Thank you, Congresswoman Lee. Yes. We would certainly agree with your approach. The primary response for dealing with the orphan crisis right now is to keep children within the community where they live and keep them with their extended family network. And that is the major approach. I would say there is an explicit link here between the microfinance programs that we have talked about by empowering women within communities through microfinance, then the community itself is more able to keep children who have been orphaned within the community. So I see that there is an explicit link there between the orphan response and the microfinance initiatives.

I would also add, though, that in many environments like in Zambia and other countries where the epidemic has already advanced, we have not responded sufficiently so there already are more orphans than these extended family networks can handle in many cases. And so while we agree that community based response is the way to go, already you are seeing a large number of orphanages, orphan transit centers, all kinds of responses that are occurring that need to be overseen and monitored very carefully. We cannot ignore that that is already happening.

I think there are ways of promoting adoption even within the country or within even the family within African culture. So there are succession planning issues that need to be addressed as a child becomes orphaned.

But I would also like to reiterate an earlier point that I made is that we should not allow the process to go from where we are now, which is 13 million orphans, to the projected 40 million orphans by 2010. We should accelerate our orphans prevention strategies by making antiretroviral drugs available so we stop the orphanage.

Mr. PAYNE. Would you yield a moment?

Ms. LEE. I would be happy to yield, Mr. Payne.

Mr. PAYNE. Not that I want to get into a debate, for which I had to leave that meeting yesterday, too, but I just want to bring out

the point that in terms of GDP, the U.S. gives less than any other nation in the world—you can have your expert look that up to verify that it is true. Therefore, the notion that we are carrying—as a matter of fact, when the U.N. started, we were paying 50 percent because, of course, the rest of the world was on its knees. Then we dropped it to 33, we went down to 27, we are at 22. There is a notion that we should be no more than 20 percent and dropping, which means that Norway and Sweden will increase their donations.

Secondly, concerning peacekeeping, we started out at 33 percent, we are down to 30. We have this, as you mentioned, difference in how you calculate. We do one thing, I guess we are using inch and feet and they are using the metric system because every time we calculate our funds we have a $500 or 600 million difference from what their books say, so we say that you are wrong, your accounting system is wrong.

Now, who is wrong or right?

And then when we look at Nigeria. If you talk about airlifts and things we are doing, Nigeria has had soldiers in Liberia and in Sierre Leone for 10 years. If you take out what their GDP is and what it costs them to keep troops there, it is astounding. Britain is in Sierre Leone. France was in Rwanda.

So I think we do a good job, but I think a lot of times we do not necessarily compare apples with apples and there are a number of people, you know, Australia is in East Timor with New Guinea. We are not there. They went to Samoa and Fiji when those problems—the Australians roaming around the Southern Pacific.

So I think that those of us who have an opportunity to do things, ought to. I just think that many times we—and I am very proud that we do what we do—should just do more.

Thank you for yielding.

Mr. SMITH. Thank you. Again, just to—and I will not belabor it with our witnesses here, but we did provide the $926 million arrearages. Every one of those arrearages were disputed accounts where very often the Congress itself stepped up and said we think that expenditure is antithetical to what we believe in and therefore we will not pay it. It was bipartisan and over time it built up to a critical mass amount and unfortunately, because I met with many of the U.N. diplomats as well, became a pretext for U.S. bashing which completely overshadowed the enormous amounts of money, close to 2 billion a year, and much of that voluntary and then much of it not even included in that aggregate that we provide to the U.N.

And in our bills, my bill as well as in Hyde's and in Ben Gilman's before that, we put more money into every one of those accounts. Assessed, voluntary peacekeeping, right on down the line for the U.N. The voluntary victims of torture, under Clinton, were given a couple hundred thousand. I upped it to several million. It was in my bill, the Torture Victims Relief Act. I can go on and on. So I take a back seat to no one on that, but it disturbs me when that is used—even now, last year, Bill Clinton sent up a budget that allotted $254 million for AIDS and $150 million for the AID account. This Congress, our leadership, got it up to $300 million. It is still not enough, but the ball was moving in the direction and it was

a bipartisan effort in Congress, but we did it and now we need to do more and I think that is the point I am trying to make.

Let me also say to Ambassador Seck, the record needs to point this out if it has not already, one of the main reasons why we have invited you here to the Committee is because Senegal has done so well, 1.77 percent infection rate compared to places like Botswana with 35.8 percent, Zimbabwe with 25 percent, South Africa with almost 20 percent. You are doing something right that needs to be replicated and our hope is that the good news does go out, that you are a shining example and we are hoping to amplify that and learn from that, to do whatever we can to push it forward.

I would like to ask Mr. Scofield one final question and then if Mr. Payne has any final comments or questions or any of the panelists.

Would you explain how the credit life and health insurance can be provided to the poor suffering from HIV/AIDS in Africa? What has been your track record in the area and, very importantly, how can these programs be scaled up and ratcheted up?

Mr. SCOFIELD. I would have to say first off, we have the longest track record in credit life insurance, which again we are working with an expert, a huge international operator, AIG, where they are really handling the insurance end of it. And it is working very well and I think it is a very low cost type of service, but provides a very valuable service to people because it gives them security.

In our model, people are jointly responsible for the loan in the village bank, so if one or two die in the course of a loan cycle and leave that debt to the others, that can be a terrible burden. And so it is worth it them to pay a few cents more on the interest on their loan to get that coverage and it seems to be working quite well.

The health insurance is much more complicated, mainly because people who have very scant resources have a hard time paying for something that they may never use or they may under use. I have to say in my own case I have probably paid $100,000 for car insurance to State Farm and I probably only got back a few hundred. But it is even harder for people, as you can imagine, who live on a few dollars a day to get into the idea of pooling risk and so forth and there are going to be overusers and underusers.

That said, we have a small pilot that is providing real benefits and the people who do understand it and utilize it are really much healthier than the other control group, if you will, who do not utilize it. When there is an onset of a disease like malaria or something, if they go early and get treatment, then the consequences are much less severe health wise and financial wise.

So we see promise for this area and we are working, actually, with an advisory group of experts in HMOs and health care and insurance and so forth, so we hope to be able to do more in this area.

Mr. SMITH. Thank you.

Mr. DOKMO. Mr. Chairman, I would like to add that from Opportunity's experience, we have two pilot programs, one in Zambia, one in Uganda, and regarding the health insurance issue, it is complex and the jury is still out, so is it scalable? We will see.

What we have decided is in Ghana, we have partnered with a Ghanaian network called the Louks Society, which is a network of primary health care providers and doctors throughout the country. We are connected with them at the community level and so that our trust bank clients, our loan clients, loan recipients, will have primary health care as part of the context of their loan. And so we have focused more on the prevention in that case and it has been quite successful as one of our primary experiences.

Mr. SMITH. Thank you.

Ambassador SECK. Mr. Chairman, just a short remark. All the primary sources, talking about Uganda, South Africa, Zambia, are mostly English-speaking countries. I have the impression that maybe the average American does not know about Senegal. You are the only one to mention what happened in my country. So I think that those people who call themselves Africanists should know about the whole continent, Francophone and Anglophone. Thank you.

Dr. ZEITZ. Thank you, Mr. Chairman. I would like to make a brief comment on the funding issue and the role of the U.S. in the world. I appreciate your comments about the large contributions that we do make. But I think I would like to share sort of a perspective which is that the global economy is about $25 trillion globally. That is the money flow going around on an annual basis. The U.S. makes up 30 percent of the global economy.

Huge amounts of resources are within our influence and within our control. And the economists estimate that the global AIDS epidemic has cost the world both in direct costs and opportunity costs about $500 billion so far. These costs will continue to escalate if we do not do something about the epidemic.

So when I think the U.N. and the global consensus of economists and doctors and everyone is saying we need a $10 billion fund and we need it now, then that is a small amount of money in proportion to the cost of the AIDS epidemic and it is a microscopic part of the global economy.

And so we believe that the U.S., if it is true to its mission as laid out by our founders, we need to step up to the plate now and we need to invest some real dollars into stopping this crisis. I think it is true that we do play a large role, but, you know, people look at the United States and they say, 40 percent of American children are obese and 40 percent of African children are dying of malnutrition. This global inequity, this system that exists that creates and perpetuates the global inequity. We have to be involved. We have to assert leadership to transition that so that we can stay economically vibrant but also help other people get out of the hole and AIDS is pushing everyone faster, deeper into that hole.

Thank you.

Mr. SMITH. Thank you.

Any other comments?

Mr. Payne?

Mr. PAYNE. Yes. My time—they are calling me. Just one final point on what you have said. In addition to those numbers, you know, we have 4 percent of the world population, yet we consume 25 percent of consumption in the world. I mean, so when you look at it, you know, there are still people trying to decide whether the

science for Kyoto is really a science and whether there is really global warming and whether there are really greenhouse emissions. We have a responsibility—I mean, if we are consuming 25 percent of the world's resources with 4 percent of the population. At one time, it was higher—we represented consumption levels of up to 40 percent.

And so the whole question of responsibility, that is what I just said. My colleague, we are both from New Jersey. We debate these issues, and I think his points are certainly well taken. I think the U.S. is doing something, I just do not think it is doing enough. I know you are a former military man, Ambassador. You'll understand the notion that our troops will not serve under any other leadership but ours. However, every other country says that our troops, if it is a U.N. effort, serve together to try to overcome whatever the obstacle or the enemy is—one, we do not send troops much any more anyway, but if we do, they cannot serve under anyone else's leadership.

These are areas that become sensitive. Of course, I do not want any of our young men in harm's way any more than you want Senegalese men in harm's way. However, when we take attitudes like that, that we do not want our troops under anyone else's jurisdiction, when we will not sign a treaty on land mines, where we will not sign a treaty on children soldiers, where we will not sign a treaty on the status of women, when we will not—just recently approved—just last year, after a 10-year struggle, the U.S. Senate said we are opposed to litigation, we will approve that treaty. The International Court of Justice—we can go on and on here, there are flaws in things.

However, if we continue to isolate ourselves out of the world community, I think that is a dangerous trend. I think that we have a lot to offer the world. We have done a lot. The Marshall Plan, Europe would not be competing with us today, there would be no Airbus completing against Boeing for sales if it was not for the U.S. Marshall Plan. No question about it. However, I would like to see us return to that leadership that we used to have, that we have the capability even more so today than we were at that time. That is all.

I mean, you know I love America, I am up with America, I just think that we are not doing as much as we can. That is just my opinion.

Thank you, Mr. Chairman.

Mr. SMITH. Thank you, Mr. Payne.

I again want to thank our very distinguished witnesses for your counsel, your insights, your data that you provided us. It will be very, very useful as we go forward and I do believe it will be on both sides of the aisle very helpful as we move forward.

Please stay in touch with the Committee. If you have anything else you would like to add that you think we need to know about, just get it to us and we will make it a part of the record. And if it is past the time when the record is actually put together, we will disseminate it among the Members. So thank you so much.

The hearing is adjourned.

[Whereupon, at 3:20 p.m., the hearing was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

SUPPLEMENT STATEMENT OF THE HONORABLE ANDREW NATSIOS

Since 1986, USAID has provided $1.6 billion in HIV/AIDS assistance; we are the largest donor in the world. USAID has been working with host country partners, citizen groups, and other donors to understand and address this global concern.

Equally important, we play a critical leadership role in assuring that developing countries benefit from gains in knowledge about HIV/AIDS. We help support groundbreaking research in the United States in critical areas such as the development of vaccines and microbicides. We carry out operations and social science research in host countries to track the epidemic and to see that scientific breakthroughs are translated into effective interventions for use in developing countries. We do this through a four step process: 1) identifying relevant findings, 2) testing their utility in the resource-scarce environment of developing countries, 3) adapting the approaches to host country conditions, and 4) developing the systems, protocols and training necessary to use these approaches on a large scale. Once this is done, we help countries scale up to reach significant populations. Important milestones in this process include the following:

- In 1988 rapid, inexpensive kits were developed which made it possible to detect HIV in a prospective donor's blood. The use of this technology and these tests has changed blood collection and storage in developing countries. By screening prior to blood collection, hospitals are able to ensure safe blood supply without elaborate blood storage and testing. This approach is being used throughout the world. It has significantly reduced HIV transmission through blood transfusions.
- In 1995, a study in Tanzania showed the treatment of other sexually transmitted infections (STIs), such as chancroid and syphilis, reduced HIV transmission by nearly one half. As early as 1990, USAID had incorporated STI management in its strategic approach to HIV/AIDS. After the publication of the Tanzania study, STI treatment became one of the cornerstones of our HIV/AIDS prevention programs. In 1999/2000, periodic presumptive treatment, a new approach to the treatment of STIs among high-risk groups, was developed. This approach has been shown to reduce significantly the transmission of STIs among high-risk populations. It is an important element of programs such as our Cross-Border Program in Southern Africa, which targets high-risk populations including truck drivers, migrant workers, and prostitutes.
- In 1996–7, a USAID-sponsored study in Uganda found that those who used voluntary testing and counseling services (VCT) and knew their HIV/AIDS status changed their behavior to avoid risk. This was true of both those who were HIV positive and HIV negative. In addition, those who know their status, in many cases, became powerful educators in their community, advocates for improved care, and the creators of innovative non-governmental organizations. In Uganda, women living with AIDS helped found a NGO which helps other widows and widowers with HIV/AIDS leave a legacy through memory books for their children, many of whom will soon be orphaned. Voluntary testing and counseling is now increasingly an essential part of national HIV/AIDS programs. USAID has introduced VCT in six country programs. In Uganda, more than 500,000 people have used VCT services.
- In 1997, a Thai national policy that mandated 100% condom use in brothels resulted in a dramatic decrease in HIV and STI transmission. Thailand is one of the few developing countries in the world to succeed in keeping HIV/AIDS

prevalence low. The lessons learned from Thailand are being applied in Cambodia and the Dominican Republic.

- The first treatments to reduce mother to child transmission (MTCT) were developed in the U.S. in 1994 but were too expensive and difficult to use in a developing world setting. In 1998, pilot studies showed that a simpler, less costly, four-week treatment could be successfully used to prevent MTCT. Subsequently, USAID began to pilot test MTCT in countries where there were many HIV positive women. In 1999, U.S. financed studies found that the drug nevirapine offered an even cheaper and even simpler approach to preventing MTCT. Nevirapine only requires a single dose each for the mother and the newborn child at a cost of approximately one-dollar for the drug. This is a considerable improvement over the previous four-week treatment with other drugs. Currently, Nevirapine's manufacturer, Boerhinger Inglem, is making the drug available at no cost to developing countries. USAID is supporting pilot MTCT prevention programs in Kenya and Zambia with additional activities planned for Uganda, Malawi, Rwanda and South Africa.
- In 1998, studies in Uganda showed that delaying sexual debut by two years could have a profound impact on HIV prevalence. The prevalence rate in urban settings was cut in half. This has led to an increased emphasis on youth and education programs like Uganda's straight talk clubs.
- In 1987 two ground breaking African care programs for people living with HIV/AIDS were established: The Chikankata AIDS program in rural Zambia and The AIDS Service Organization (TASO) in Kampala Uganda, an urban setting. Both programs demonstrated that community supported, home-based care programs were feasible at relatively low cost. USAID is expanding its support for home and community based care programs.

  Plans are underway to expand our programs to include training for health care workers and to improve health infrastructure to meet the growing demand for AIDS care services. The highest priority will be to expand access to treatment for tuberculosis (TB) and other opportunistic infections to reduce suffering and prevent and delay deaths. TB is the most common opportunistic infection in the world and the leading cause of death for persons living with HIV/AIDS.
- In 1997 USAID published *Children on the Brink* which for the first time enumerated the large numbers of children orphaned by HIV/AIDS especially in sub Saharan Africa. This was followed up by *Children on the Brink 2000*. At the end of 1999, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that 13.2 million children under age 15 world-wide had lost their mother or both parents as a result of AIDS; 90 percent of these children live in sub-Saharan Africa. USAID estimates that 44 million children in 34 countries hardest hit by HIV/AIDS will have lost one or both parents from all causes, but primarily from AIDS, by 2010. USAID has initiated 40 programs in 18 countries to care for children affected by the HIV/AIDS pandemic. These programs are focused on providing communities with the assistance they need to keep orphans and vulnerable children in the community, and to ensure they are provided with an education and food.

USAID is currently supporting applied research in 21 countries. This includes research to develop and improve our approaches to: reaching youth with effective services and messages; integrating HIV testing services into existing health care settings; improving programs to prevent mother to child transmission of HIV; providing home and community based care for persons with HIV/AIDS; assisting children affected by HIV/AIDS; and reducing the stigma of HIV/AIDS so that persons affected can freely use the services that are available.

In addition, USAID supports efforts to develop an AIDS vaccine, preventive microbicides, STI diagnostic tools, and new methods of measuring the extent and impact of the epidemic.

We are having a powerful impact on the global pandemic with the tools available now. However, there is no single intervention that slows transmission, comforts the sick, or cares for those affected. In each country, we must determine the state of the epidemic in both biomedical and behavioral terms. Once we know who is infected, who is at greatest risk, the dominant forms of HIV transmission, and the numbers and needs of those infected and affected, we can apply the right mix of interventions.

USAID's strategy has two important elements: a geographic focus and a programmatic focus. Although we work in 50 countries, we concentrate resources in 20

countries. These countries have been selected on the basis of the severity of the epidemic, risk of rapid increase of infection and national willingness to act.

USAID is now aggressively pursuing six strategies for fighting the HIV/AIDS pandemic worldwide.

- *Prevention* remains the cornerstone of USAID's program. Special attention is given to scaling up proven approaches, ultimately to a national scale. We can and must reach youth early with prevention messages. Almost half of all of new infections in developing countries are to 15 to 24 olds. We target high-risk populations to change behavior through abstinence, faithfulness and the use of condoms to slow the spread of the virus to the general population. High priority is given to diagnosis and treatment of sexually transmitted infections in these groups. We support the gradual introduction and expansion of programs to prevent mother-to-child transmission through the provision of limited medications for mother and newborn. Finally, promotion of voluntary counseling and testing has proven to be a highly effective way of achieving behavior change, eventually slowing transmission.
- *Care and support:* We focus care interventions to reach the most vulnerable populations, and those with the greatest potential to prevent transmission where possible, and improve the quality of life of infected individuals. Our support to people living with AIDS is focused on the prevention and treatment of AIDS-related illnesses like tuberculosis and other opportunistic infections. These conditions can be treated with low cost, more readily available medicines. This can reduce suffering and prevent premature death.
- *Orphans and vulnerable children:* Our help to orphans and other vulnerable children is focused on the areas worst hit and draws upon community resources to develop programs and solutions. In Zambia, for instance, the USAID mission provides small grants to community organizations which determine what is needed to help them care for the children in their midst. These range from providing seed, fertilizer, and help with plowing (the elders caring for their many grandchildren are not strong enough to plow) to community schools which use transmitted instruction and community volunteers to educate the children. In Zambia, more teachers are dying each year than graduate from Zambia's teaching colleges.
- *Increasing surveillance capacity to track the epidemic:* USAID supports programs to monitor the status of the epidemic, measure the impact of prevention and care programs, coordinate donor and other partner activities, and use resources most effectively.
- *Encouraging greater financial commitments of other donor governments and multi-lateral institutions in the fight to combat the disease:* USAID recognizes the need to generate additional financial and human resources through multinational initiatives such as the Global HIV and Health Fund.
- *Engaging National Leaders and other Sectors in the Fight:* We must enlist the active, sustained and visible support of national political leaders in mobilizing their own governments to change people's behavior and to address the pandemic. Mitigating the consequences of the HIV/AIDS pandemic requires a broad, multi-sectoral approach. I have recently sent a cable to our missions telling the Agency that HIV/AIDS is not just a health issue and every USAID officer in every sector must consider AIDS programming.

And finally, USAID is committed to a sustained and significant effort. We know from Uganda, from Senegal and from Zambia that it takes a sustained commitment to realize gains and that until infections are substantially reduced globally, we can not diminish our efforts.

I am determined, as the Administrator of USAID, that with your support we will meet this challenge. When we look back 10 years from now at our legacy, we will be able to say that the generosity and know-how of the American people made a difference and saved many.

PREPARED STATEMENT OF THE HONORABLE BARBARA LEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

I would like to begin by thanking Chairman Hyde and Ranking Member Lantos for holding today's hearing on HIV/AIDS.

I believe that the timing of today's hearing is extremely timely since the world community including the United Nations member countries, international AIDS

service organizations and representatives of civil society are preparing for the United Nations General Assembly's Special Session on HIV/AIDS (UNGASS).

Much of the preliminary discussion prior to the UNGASS has been about the establishment of a multilateral, multisectoral strategy to address the African and global AIDS crisis.

As many of you know, my colleague, Congressman James Leach from Iowa and I laid the ground work for the establishment of such a fund. The World Bank AIDS Trust Fund. This was signed into law by President Clinton, P.L. 106-264.

1.65 million Africans have died from AIDS since the trust fund was authorized.

We also worked to ensure that there were significant increases for the United States' domestic and international HIV/AIDS programs.

It has however, become a stark reality that today, 36.1 million people are estimated to be living with HIV/AIDS, including over 1 million children.

Approximately 95% of the world's HIV/AIDS cases are in the developing world and, over 70% are in sub-Saharan Africa.

We know that HIV/AIDS is decimating the continent of Africa and leaving behind millions of orphans in its wake.

We know that HIV/AIDS is a national security threat and a potential economic catastrophe.

We know that this is the greatest humanitarian crisis of our time.

In Congress, our commitment to attacking this issue is growing. Yet, the White House and the Bush Administration continues to drag their feet on this issue.

This year, the Bush budget flat funded our domestic HIV/AIDS programs, including the Minority Health Initiative which was led by the Congressional Black Caucus.

This year the Bush Administration also announced that the U.S. would contribute $200 million dollars to a global AIDS fund. On closer examination, that contribution took money from other critical programs such as peacekeeping efforts, allergies and infectious disease control, as well as other child survival accounts. It robs Peter to pay Paul.

I would like to remind my colleagues that over 6,000 people are dying each day from this horrific disease.

AIDS has killed 22 million people worldwide. This is not the middle or the end of this pandemic, this is just the beginning.

AIDS is the plague of the 21st century and it is not done with us yet.

Again, in two weeks, the United Nations General Assembly will hold a special session on HIV/AIDS. In the meantime, UN member nations are at work on a declaration on HIV/AIDS to be signed at that meeting.

I am troubled by reports from the grassroots community that as this document is being drafted, a cohort of countries, including the United States, are working vigorously to block any provisions that would include the most vulnerable populations affected by HIV/AIDS, including gay men, sex workers, and intravenous drug users. This is a moral outrage.

Also disturbing are reports that the United States is also seeking to block language which would make access to lifesaving medicines a basic human right.

The United States must not revert to archaic policies that would only exacerbate the AIDS pandemic.

We must stop this policy of indifference; it is criminal.

I encourage my colleagues to oppose any such language in an international document. I also encourage my colleagues to advocate for the highest level of funding possible to address this global pandemic.

Thank you.